CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Bailey Mackander
File number:	2019/351386
Hearing dates:	3-7 May, 18-22 October, 9 November 2021
Date of findings:	15 December 2021
Place of findings:	Coroners Court, Lidcombe
Findings of:	Deputy State Coroner E. Truscott
Catchwords:	Coronial Law - Cause and manner of death - First Nations death whilst in lawful custody of Corrective Services NSW - Hospital escort - Escape - Intent to self-harm - Risk Intervention Team treatment
Representation:	***Counsel Assisting*** Ms T Stevens instructed by Ms T Bird of the Crown Solicitor's Office ***Tracy Mackander*** Mr W de Mars instructed by Ms R McMillan of Legal Aid NSW ***David Mackander*** Ms G Lewer instructed by Mr M Ward of Morrisons ***Commissioner of Corrective Services NSW, Ricky (Rick) Lloyd, Erin Hyde*** Ms G Mahony instructed by Ms J De Castro Lopo of Department of Communities and Justice, Office of General

	Counsel ***Wheturangi Uerata, Ricky (Rick) Slingsby*** Mr R Reitano instructed by Ms C Hatzigeorgiou of McNally Jones Staff Lawyers ***Justice Health and Forensic Mental Health Network and Central Coast Local Health District*** Mr P Rooney instructed by Ms R Cooke of Hicksons Lawyers ***Dr Stephen Cameron*** Ms K Burke instructed by Ms C Darroch (3-7 May 2021) and Mr N Audet (18-22 October and 9 November 2021) of Meridian Lawyers ***Ms Lara Georgiou*** Ms Z Alderton instructed by Ms L Toose of the NSW Nurses and Midwives' Association
Findings:	**Identity** Bailey Mackander was a 20 year old Wiradjuri man. **Date of Death** 7 November 2019 **Place of Death** Royal North Shore Hospital, St Leonards, NSW **Cause of death** Multiple injuries from fall from height **Manner of death** Bailey was on remand in the lawful custody of CSNSW and died after he impulsively ran from the custody of CSNSW escort officers and vaulted over the Gosford Hospital ambulance bay wall without realising that the wall was not at ground level but was approximately eight metres above. At the time Bailey escaped he was handcuffed and ankle shackled and was subject to a Risk Intervention Team

	Management Plan which caused him to be held in an assessment cell. Whilst in the assessment cell that day, he was without any psychological or social support or access to the open air and was deprived of any diversionary activities involving human interaction and telephone calls. Bailey had a substance use disorder in conjunction with or additional to a generalised anxiety disorder. He struggled with being in prison and he especially struggled with being in the assessment cell. He fabricated stomach pains and a story that he had swallowed metallic foreign objects to attend hospital so that he could have time away from the cell. His escape was impulsive in circumstances where he knew he was about to enter the escort vehicle to return to the cell, without any certainty that he would be discharged from that cell the following day.
Orders:	The Court made specific non-publication orders pursuant to s. 74 of the *Coroners Act 2009* and non-access orders pursuant to s. 65 of the Act. The orders generally relate to sections of Corrective Services NSW material, Justice Health and Forensic Mental Health Network material and sensitive material. The orders are available via the Court registry. One pseudonym, “John Brown”, has been applied.
Recommendations:	See Appendix A

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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 young First Nations man, Bailey Mackander, who was 20 years old when he died from catastrophic injuries after falling eight metres when he jumped over a wall at an ambulance bay at Gosford Hospital ("the Hospital").

2. On 5 November 2019, Bailey (who was an inmate on remand at Kariong Correctional Centre ("CC")) was discharged from the Emergency Department ("ED") of the Hospital. While one of the escorting correctional officers was opening the prisoner door of the transport van for the purpose of returning Bailey to Kariong CC, Bailey stepped back. Although shackled at hand and foot, Bailey took three to four fast steps towards the wall, placed his hands on the top of the wall, and sprung his legs over. One correctional officer leapt onto the wall, but upon seeing the distance below he could not proceed so he ran down the ramp to Bailey. Paramedics and police officers who were at the ED immediately attended to Bailey and he was admitted to the Hospital, before being transferred to Royal North Shore Hospital ("RNSH"). Bailey was placed on life support but his injuries were irrecoverable and on 7 November 2019 Bailey died with his parents and family around him.[1]

3. Bailey, like his father David, was a Wiradjuri man. He was born on 24 December 1998. Bailey was the son of Tracy and David and although they separated when he was 10 years old, Bailey remained extremely close to both of them and lived with each of them at different times. Bailey was the younger brother of Tracy's older son, Kaine. David remarried and he and his wife Melissa had twins Molly and Max and later sons Angus and Leo. Bailey also had two step-sisters. Bailey was also very close to Melissa and his brothers and sisters. Sadly, when Bailey was 14 years old, Molly died about a

[1] I note that the Certification of Brain Death (Ex 1, Tab 3) and Report of a Death of a Patient to a Coroner (Form A) (Ex 1, Tab 2) state that the date of death was 6 November 2019 at 4:45pm (being the time at which brain death was declared). According to the *Human Tissue Act 1983* at s. 33(a), for the purposes of NSW law, a person has died when irreversible cessation of all functions of the person's brain has occurred. However, the autopsy report (Ex 1, Tab 5) at p. 2 provides that Bailey's date of death was 7 November 2019 (the date on which life support was turned off).

month after her second birthday. Bailey was very much affected by Molly's death and his father David believes that this is the time that things started spiralling. Bailey started smoking cannabis and truanting school. He left school in year 9 and started working as an apprentice carpenter in David's building company.

4. Bailey was raised in the Nelson Bay and Newcastle area. He grew up surfing and skateboarding, loving sport - running, soccer, swimming - but he gave this up when he started smoking cannabis and getting into trouble. He developed anxiety and when he was about 15 years old, Tracy took him to their doctor and Bailey started taking medication for anxiety and attended counselling. Unfortunately, after a few months he stopped and continued using cannabis and truanting from school. Bailey stopped socialising with his sports friends and started mixing with a different group of people.

5. Bailey started using methamphetamine and when he was just 16 years old he attended the Ted Noffs drug detoxification service at PALMS in Randwick in January 2015. He did not remain there and went to his mother's place. On 28 January 2015, Tracy took Bailey to the Emergency Department of John Hunter Hospital and the discharge summary indicates his presentation was for "*worsening suicidal ideation … anxiety and distress in the context of cannabis and methamphetamine use disorder*". Later that year, Bailey was arrested and spent a short time in juvenile detention.

6. David said that life became a cycle of rehabs, restarting drugs and going off the rails. Bailey was working on and off but by early 2018, Bailey was using methamphetamine heavily and was living between friends and Tracy.

7. In September 2018, Bailey moved to Newcastle, sleeping on friends' couches. On 7 December 2018, he was arrested and bail refused. Bailey was sentenced and remained in custody until his release on parole in March 2019. He served most of his time in a privately managed CC and his family made sure that he had weekly visits. He would telephone Tracy most days crying as he did not cope with being in prison. David said that Bailey was having a hard time in prison and he wanted to change. Although Bailey was in protective custody, he was assaulted on some occasions and when Tracy visited him she would see his injuries, such as bruises and a cut mouth. Tracy later learned that Bailey had been injecting heroin and methamphetamine while in the privately managed CC.

8. On 4 April 2019, Bailey was released on parole and lived with Tracy for a short time. She took him to the doctor to address some medical issues and he was diagnosed with

Hepatitis C (Hep C). Bailey was also to take his anxiety medication. Bailey met up with a friend and it became apparent that he had started using methamphetamines again. By the end of April 2019, Bailey had left Tracy's home and moved into another person's place in Newcastle. David spoke with Bailey and he told his father that "*he missed his brothers and he wanted to go to rehab but he couldn't kick the drugs*". Tracy and the parole officer's efforts to have Bailey enter a rehabilitation program were unsuccessful and he continued to use methamphetamine.

9. In July 2019, Bailey was arrested again. He was bail refused and was transferred to Shortland CC then to Lithgow CC, via John Moroney CC.

10. Tracy visited Bailey in Lithgow CC and he seemed settled and not using drugs. A week later he was transferred to Parklea CC[2] and when she visited him there she reported that he looked terrible because he was using drugs again. Bailey told Tracy that using drugs was his way of coping in gaol because he found it so hard in prison. On 30 October 2019, Bailey was transferred to Kariong CC.

11. On 2 November 2019, Bailey telephoned David and said that he had "*rehab lined up and had been going to church*. *He seemed happy. He talked about getting out when he next went to court in December*". On 3 November 2019, Tracy visited Bailey and she reports that he was really positive, he was attending Narcotics Anonymous and he told her he had made an appointment to see the psychologist the next day. Bailey spoke again with Tracy on 4 November 2019. He was very distressed because after seeing the psychologist he was placed on a Risk Intervention Team ("RIT") status and he was not coping in the cell. Tracy told him that she would call someone at the prison to help settle him. That was Tracy's last phone call with Bailey. The next time she saw him, he lay dying in a hospital bed.

12. The evidence in the inquest about Bailey's last days at Kariong CC on 4 and 5 November 2019 have caused much distress to not only Bailey's family, but also those involved in his hospital escort and the investigation into his time in the RIT cell, such that some people have not been able to return to work. Bailey was a gentle, loving young man who struggled with a relentless methamphetamine addiction. Despite the unconditional support his parents gave him, he was unable to stop using.

13. Bailey's story is that of so very many young men who, despite the love and support of family and with their whole lives ahead of them, become literally and in every way

[2] CSNSW do not operate Parklea CC.

destroyed by methamphetamine. This inquest is a convincing example of how prisons are no place for people like Bailey.

14. A photo of Bailey was given to the inquest. He is handsome, young, with sweet almond eyes and he smiles big, really big. He looks like his Mum. He looks like his Dad. Though they did not raise him to end up in prison and though they did not raise him for his life to end the way it did, they are left to live with it. To Tracy and David and Melissa and Bailey's brothers Kaine, Max, Angus and Leo and other family members and friends, I extend my sincere condolences for their terrible loss.

Jurisdiction

15. This inquest is held pursuant to ss. 23 and 27 of the *Coroners Act 2009* ("the Act") which requires an inquest to be held for any person who dies in lawful custody and that such an inquest is held by a senior coroner.

16. Under s. 81 of the Act the coroner is required to make findings as to the identity, date, place, and cause of death (which are not controversial in this inquest), as well as the manner of death which encompasses the circumstances of and surrounding a death. Under s. 82 of the Act, if the coroner considers that it is necessary or desirable to do so, the coroner can make recommendations about matters arising from a person's death.

Evidence

17. The brief of evidence contains seven volumes of documents, photographs and CCTV recordings. Further material was tendered during the hearing. Evidence was taken over nine days and submissions were made by counsel assisting on 22 October 2021 (day 10) and by parties on 9 November 2021 (day 11). Of the 18 witnesses that were called, three psychiatric experts gave their evidence in conclave (on 20 October 2021). The other witnesses included Ms Erin Hyde (née Minard), a psychologist employed by Corrective Services NSW ("CSNSW") and Ms Lara Georgiou, a registered nurse in the employ of Justice Health and Forensic Mental Health Network ("Justice Health") who gave particularly important evidence over a time in the witness box, for which I wish to extend my appreciation.

18. Bailey's cell mate (known in the inquest as "John Brown"), although not interviewed at the time by either the investigating police or to my knowledge CSNSW officers, gave evidence. Remarkably, after learning of Bailey's death, Mr Brown had the foresight and common sense to reduce to writing his recollections of events and his 15 page

record is included in the brief of evidence.[3] It is a reminder to coronial investigators that when inquests are held in relation to deaths in custody, particularly those of First Nations' peoples, events leading up to these tragedies contain important evidence which should be collected.

19. Though the initial investigation focussed on the environment and immediate circumstances at the Hospital's ambulance ramp, and evidence was taken in regard to that from escort officers Correctional Officer ("CO") Rick Slingsby and CO Wheturangi Uerata, it was the events in the days leading up to that time which became the focus of the inquest.

20. The inquest was concerned with questions as to the manner of Bailey's death, including whether he intended to harm himself, intended to escape from custody or simply did not want to be returned to the observation cell in which he had been placed the previous day (known as being placed "on a RIT").

21. Whether Bailey was appropriately placed "on a RIT" and in the observation cell, and whether his review and management whilst on the RIT were appropriate, were issues in the inquest. In that regard, a number of CSNSW staff gave evidence including Senior CO ("SCO") Ricky (Rick) Lloyd, who co-ordinated the RIT review with other members Ms Marian Thompson (a Special Programs and Activities Officer ("SAPO")) and RN Georgiou (employed by Justice Health). CO Mr Terry Dolling gave evidence as to his participation in the RIT review. Ms Hyde, CO Ms Kelly-May Dolling, and CO Ms Jennisa Grimshaw gave evidence about how Bailey came to be placed on a RIT and how he was managed in the cell on the first day.

22. SCO Mr Peter Cargill gave evidence in relation to Bailey's management in the cell on both 4 and 5 November 2019 and in relation to Bailey's escort transfers to the Hospital on both evenings. The observation cell occupied by Bailey did not have access to a yard as that had been closed off due to possessing "*hanging points*". The cell had television facilities and a toilet and access to a shower. It was subject to constant surveillance by CCTV which could be observed on a monitor in a nearby officers' room as well as in a central control room. There was a cell intercom that allowed, via the pressing of a button, audio communications between the cell's occupant and a CO. This is sometimes known by its vernacular as a "knock up". I will refer to the use of the cell intercom as a "cell intercom call"[4] ("CIC"). Though a log of observations was not

[3] Ex 1, Vol 6, Tab 76.
[4] Taken from the terminology in Dr Eagle's report at Ex 1, Vol 5, Tab 74.

kept, digital records of times of the CICs and a recording of what was said by Bailey and the respective officers was copied and provide to the inquest by CSNSW. Some CICs were made which received no response or dialogue. Some of the witnesses such as Mr Cargill and Ms Grimshaw were officers who communicated with Bailey; other officers who communicated with him were not called to give evidence. A transcript of the calls and dialogue was tendered as evidence in the inquest.

23. Those assisting the coroner sought an expert report from Dr Kerri Eagle (forensic psychiatrist) who amongst other matters, indicated in her report various concerning features about the CSNSW RIT process being used as a means to address inmates at risk of self-harm. The Central Coast LHD and Justice Health jointly obtained a report from Dr Richard Furst in regard to that and other matters. Professor Matthew Large was also invited to attend the conclave, although his report addressed an issue of narrower compass. Dr Sarah-Jane Spencer (forensic psychiatrist and Co-Director of Justice Health's Services and Programmes and Custodial Mental Health) provided a statement and evidence in response to the experts' evidence.

24. Evidence was also taken from Mr Michael Hovey (Director of CSNSW Investigations Branch) who was the lead investigator into Bailey's death as well as from Mr Terence Murrell (General Manager of State-Wide Operations, CSNSW).

A brief outline of Bailey's history in custody prior to his transfer to Kariong CC[5]

25. Bailey was in juvenile detention for a short time in late 2015, during which time he seemed to not cope with detention and required psychological support. Perhaps relevantly and tragically ironic to this inquest, Justice Health records of November 2015 contain nursing notes which record Bailey was considering self-harm in order to go to hospital, however he was not suicidal.

26. On 11 November 2015, Bailey was seen at a Justice Health clinic after an alleged altercation with another inmate and on 27 November 2015, the mental health clinical nurse consultant saw Bailey and determined that he had anxiety (exacerbated by situational stressors) and made a plan for review by a psychiatric registrar on 2 December 2015.[6]

[5] Paragraphs [25]-[50] are extracts from Ms T Bird's letter of instruction to Dr Eagle dated February 2021 at Ex 1, Vol 5, Tab 74.
[6] Ex 1, Vol 3, Tab 40, Justice Health records, Progress Note dated 27 November 2015, pp. 21-24.

27. Bailey entered adult custody for a short time from 3 to 6 July 2018. He commenced his first extended period of time in adult custody on 7 December 2018. Bailey was housed in the privately managed CC from 15 December 2018 until his release on parole on 4 April 2019. During his time in custody the records relevantly indicate that on 8 December 2018 his Kessler-10 ("K-10") score was recorded as in the "*severe*" range.[7] On 28 December 2018, Bailey told a psychologist he had fleeting thoughts of self-harm upon entering custody but no plans and agreed to inform staff if his risk of self-harm increased.[8]

28. On 16 January 2019, Bailey was assaulted by another inmate.[9] On 21 January 2019, Tracy telephoned Parklea CC as she was concerned Bailey was not coping. Bailey was seen by a psychologist and was to remain on an open referral line for monitoring purposes.[10]

29. On 29 January 2019, Bailey was placed on a RIT after he made a CIC saying that he was "*not right in the head*" and needed to go to the main clinic as he had "*thoughts of slashing up*".[11] A Justice Health nurse completed a Health Problem Notification Form ("HPNF") and recommended a modesty gown, safety blanket, nil sharps and CCTV observation every 15 minutes.[12] An alert was generated for a history of self-harm incident. On 30 January 2019, apparently at a RIT review Bailey said he was "*loving life*" and he was cleared from RIT status.[13]

30. On 12 February 2019, Bailey reported that he had been assaulted by his cell mate.[14] On 16 February 2019, he was taken to the Justice Health clinic after he reportedly had a fight with another inmate, although he denied that occurred and no injuries were identified.[15] On 3 March 2019, Bailey was observed on CCTV to be punched in the face by another inmate during a fight in the yard, resulting in a cut to his lip which was

[7] Ex 1, Vol 3, Tab 41, Justice Health records, K-10 Self Report Assessment dated 8 December 2018, pp. 21-22.
[8] Ex 1, Vol 3, Tab 42, OIMS note of Mark Wright dated 28 December 2018, p. 5.
[9] Ex 1, Vol 3, Tab 42, OIMS note of Naomi Hopping dated 16 January 2019, p. 6; Tab 41, Justice Health records, Alleged Assault/Incident Form dated 16 January 2019, p. 30.
[10] Ex 1, Vol 3, Tab 42, OIMS note of Andrew Redden dated 21 January 2019, p. 6.
[11] Ex 1, Vol 3, Tab 42, OIMS note of Jed Atherton dated 29 January 2019, p. 7.
[12] Ex 1, Vol 3, Tab 42, Justice Health records, HPNF dated 29 January 2019, p. 5.
[13] Ex 1, Vol 4, Tab 46, CSNSW Investigation Report dated 6 November 2020, at [30], [107]; Ex 1, Vol 3, Tab 42, OIMS note of Nicholas Walker dated 30 January 2019, p. 7.
[14] Ex 1, Vol 3, Tab 42, OIMS note of Au Anne Tagaloa dated 12 February 2019, p. 8; Ex 1, Vol 3, Tab 41, Alleged Assault/Incident Form dated 12 February 2019, p. 31.
[15] Ex 1, Vol 3, Tab 41, Justice Health records, Progress/Clinical Note dated 16 February 2019, p. 19; Alleged Assault/Incident Form dated 16 February 2019, p. 29.

bleeding. He refused police intervention and stated he had no issue with returning to the wing.[16]

31. On 19 March 2019, Bailey requested to speak to someone as he had been feeling very stressed and down, had not been sleeping and had "*been trying to see someone for the last 3 months and no one has come to see me*".[17]

32. Bailey was released to parole on 4 April 2019. He was on parole for three and a half months until he was arrested for fresh offences on 16 July 2019. Whilst in the police cells he complained of chest pains and was attended to by an ambulance.[18] The following day, on 17 July 2019 at approximately 10:55am, COs saw Bailey in his cell and he appeared unwell and was unresponsive, although his vital signs and breathing appeared normal (and CSNSW staff considered that he was choosing to be non-responsive). Bailey was conveyed via ambulance to Mater Hospital for assessment and admission with a preliminary diagnosis of exacerbation of hepatitis.[19] He was returned to court where he was refused bail.

33. On 18 July 2019, Bailey was transferred to Shortland CC. His K-10 score was consistent with mild depression and/or anxiety disorder. The Inmate Identification and Observation ("IIO") form records he was taking Diazepam daily, had used the drug "ice" and marijuana four hours previously, stated he was upset and showed signs of being depressed and anxious with an aching chest.[20]

34. On 18 July 2019 there are two HPNFs. At 7:34pm, normal cell placement was recommended. At 8:11pm, a HPNF recorded that CSNSW were to watch out for possible detoxification symptoms and house Bailey in the clinic under camera monitoring until cleared by Justice Health. On 19 July 2019, a HPNF recommended a "*green card*", that CSNSW look out for symptoms including anxiety, encourage the drinking of fluid and alert health centre staff promptly if Bailey's condition changed (until 2 August 2019).[21]

35. On 29 July 2019, Bailey was transferred to Lithgow CC but had a few days in transit at John Morony CC.[22] A HPNF recommended that CSNSW watch out for unusual or isolative behaviour and that he be placed in two-out cell placement until cleared by

[16] Ex 1, Vol 3, Tab 42, OIMS note of Sau Anne Tagaloa dated 3 March 2019, p. 9; see also, Ex 1, Vol 3, Tab 41, Justice Health records, Alleged Assault/Incident Form dated 3 March 2019, p. 32.
[17] Ex 1, Vol 3, Tab 41, Justice Health records, Patient Self-Referral dated 19 March 2019, p. 24.
[18] Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 16 September 2019, p. 45.
[19] Ex 1, Vol 3, Tab 46.3, Case Management File, CSNSW Incident Details Report dated 17 July 2019, p. 88; Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 17 September 2019, p. 45.
[20] Ex 1, Vol 4, Tab 46.2, CSNSW Warrant file, IIO form, p. 17.
[21] Ex 1, Vol 3, Tab 43, Justice Health records, HPNF dated 19 July 2019, pp. 32-34.
[22] Ex 1, Vol 4, Tab 47, Inmate Profile Document dated 10 November 2020, p. 3.

Mental Health.[23] On 4 August 2018, Bailey was assessed in the Justice Health clinic after a fight with his cellmate, however no injuries were noted.[24]

36. On 6 August 2019, Bailey attended a consultation with a mental health nurse and reported being anxious and teary, having difficulties sleeping, panic attacks, vomiting and lack of appetite.[25] He was referred to a general practitioner ("GP") and a psychiatrist commenced Bailey on anti-depressant medication, Mirtazapine.[26]

37. Bailey arrived in Lithgow CC on 9 August 2019. On 10 August 2019, he reported fearing from his life from his cell mate and was relocated.[27] On 19 August 2019, Bailey indicated he had last injected "Bupe" in custody the previous week.[28]

38. On 31 August 2019, Bailey presented to the Justice Health clinic with reported chest pain for two days which was found to be related to anxiety.[29] He was anxious or stressed about being in gaol and was given Rennies and paracetamol. The Justice Health note records "*W/L made for MH. Recommended to CS they make appointment for psychology for patient. Pt. given pamphlets on relaxation techniques*". An ECG was also performed.[30]

39. On 3 September 2019, Bailey was found to be HCV (Hepatitis C Virus) positive.[31] Bailey consented to seeing a psychologist and he was to be seen by psychology weekly.[32]

40. On 9 September 2019, Bailey appears to have been moved to a different accommodation unit upon his request, however it is noted he was "*[s]till showing signs that he is not coping with being at Lithgow*".[33]

41. On 10 September 2019, Bailey was transferred to Parklea CC where he remained for six weeks until his transfer to Kariong CC on 20 October 2019.

42. On 12 September 2019, Bailey attended a mental health nurse and reported that he was feeling distressed after being advised his court case was adjourned to January

[23] Ex 1, Vol 3, Tab 43, Justice Health records, HPNF dated 29 July 2019, p. 26.
[24] Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 4 August 2019, p. 46; Alleged Assault/Incident Form dated 4 August 2019, p. 144.
[25] Ex 1, Vol 3, Tab 43, Justice Health records, Mental Health Triage dated 6 August 2019, p. 43.
[26] Ex 1, Vol 3, Tab 45, Justice Health Incident Summary dated 21 January 2020, p. 1.
[27] Ex 1, Vol 4, Tab 46.3, CSNSW Case Management File, Incident/Witness Report, p. 107.
[28] Ex 1, Vol 3, Tab 43, Justice Health records, p. 69.
[29] Ex 1, Vol 3, Tab 45, Justice Health Incident Summary dated 21 January 2020, p. 1.
[30] Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 31 August 2019, pp. 47-48.
[31] Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 3 September 2019, p. 48.
[32] Ex 1, Vol 4, Tab 48, OIMS note of Jennifer Mackie dated 3 September 2019, p. 32; Ex 1, Vol 34, Tab 49, Form 3A – Psychology Participant Information Statement and Consent dated 3 September 2019.
[33] Ex 1, Vol 4, Tab 48, OIMS note of Geoffrey Hunt dated 9 September 2019, p. 33.

2020.[34] He was "*desperate to be released*", reported being stood over and said he felt fearful and anxious all the time and had nightmares. He reported he cried every day, felt sick, had shortness of breath, could not eat and that sleep was horrible. A comment recorded *"(likely he is giving his mirtazapine [sic] away)??".* The impression was acute stress on the back of anxiety and situational exacerbation. The recorded plan included a threat assessment, mental health review and to speak to his mother regarding bail. It was noted that if he was not released to bail he would need additional mental health follow-up and review of his medications and "*mx*", and that information was to be handed over to the Area 5 supervisor.[35]

43. On 13 September 2019, Bailey was seen by Justice Health nursing staff in the clinic. He stated he had epigastric and back pain. He was given Panadol, his regular Mirtazapine and booked for a GP review.[36] The impression recorded was that Bailey had GORD (Gastro-Oesophageal Reflux Disease) and he was prescribed a proton-pump inhibitor for epigastric pain.

44. On 15 September 2019, a "CERT" call was placed and Bailey was seen by a nurse for chest pain and reported ingesting a small balloon six days prior "*on transit*". A GP was informed and he was placed in a health clinic camera cell.[37]

45. On 17 September 2019, Bailey saw an Aboriginal Health worker for social and emotional wellbeing support. He denied being at risk of self-harm.[38] On 18 September 2019, Bailey saw a nurse regarding his complaints of lower abdominal pain. An x-ray was booked as advised by the GP.[39] The imaging request noted "*reports swallowing needles _> ? attempting to transfer out of facility*".[40]

46. On 19 September 2019, the x-ray findings recoded that *"[t]here is a radio-opaque foreign body projected over the mid abdomen to the left of the midline, compatible with a razor blade or fragment. This most probably lies in the body of the stomach, please arrange follow up x-ray if required…..*".[41] The plan prescribed that Bailey should remain in the Justice Health clinic and be reviewed by a doctor, to obtain stool samples, to give Paracetamol, and for a repeat x-ray to be conducted.[42]

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[34] Ex 1, Vol 3, Tab 45, Justice Health Incident Summary dated 21 January 2020, pp. 1-2. Also see, Ex 1, Vol 4, tab 48, OIMS note of Gail Hullett dated 12 September 2019, p. 33.
[35] Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 12 September 2019, pp. 48-50.
[36] Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 13 September 2019, p. 50.
[37] Also see, Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 13 September 2019, p. 50.
[38] Ex 1, Vol 3, Tab 43, Justice Health records, Justice Health Progress Note dated 17 September 2019, p. 53.
[39] Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 18 September 2019, p. 53.
[40] Ex 1, Vol 3, Tab 43, Justice Health records, Imaging request dated 18 December 2019, p. 37.
[41] Ex 1, Vol 3, Tab 43, Justice Health records, Medical Imaging Report dated 20 September 2019, p. 143.
[42] Ex 1, Vol 3, Tab 43, Justice Health records, Progress Note dated 20 September 2019, p. 56.

47. On 20 September 2019, RN Glenn Blundy completed a HPNF setting out that Bailey had allegedly swallowed razors, and instructing officers to "*[w]atch for reduced conscious state, [b]lood in stool, vomiting*" and recommended that Bailey be housed in a clinic dry cell for monitoring until he was cleared by his GP.[43] On a version of the form signed by the CSNSW officer, the words "*dry cell*" were crossed out by hand.[44] Bailey was medically reviewed and noted to be "*desperate*" for a hospital transfer, stating he had issues with a cellmate and was "*visibly frightened at thought of being cleared*". He was to be re-examined the following day.[45]

48. On 21 September 2019, a Justice Health nursing welfare check occurred with no issues reported.[46] At 11:38am, RN Brooke Hampson completed a HPNF recommending Bailey be transferred to normal cell placement, noting he guaranteed his own safety.[47] On the same date, a medical officer at the privately managed CC requested that Bailey be reviewed at Blacktown ED, noting his recurrent epigastric pain and that foreign body ingestion was confirmed on x-ray, although there was no evidence of perforation (as at 19 September 2019). The medical officer recorded that "[*h]is history is unreliable but collateral hx indicates has swallowed a syringe, unclear as to when, possibly 5-6 days ago. Given the ongoing pain/time I do not think the object will pass".*[48] Bailey was conveyed to Blacktown Hospital. A progress note records that he swallowed "ice" and buprenorphine wrapped in sticky tape and a needle two weeks prior. It was determined that no intervention was required and he was to be reviewed in the ED if there were further concerns.[49]

49. On or around 22 September 2019, Bailey was assessed by a mental health nurse upon his request. He said he wanted to be assessed as mentally ill to avoid a gaol term because it was very hard in gaol. He denied thoughts of self-harm, suicidal intent or suicidal ideation.[50]

50. On 27 September 2019, Bailey was taken to the Justice Health clinic after reportedly being assaulted in the yard. He was visibly upset. A laceration to his lip was glued. [51]

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[43] Ex 1, Vol 4, Tab 46.3, CNSW Case Management File, HPNF dated 20 September 2019, p. 76.
[44] Ex 1, Vol 3, Tab 43, Justice Health records, HPNF dated 20 September 2019, p. 25.
[45] Ex 1, Vol 3, Tab 43, Justice Health records, Justice Health Progress Note dated 20 September 2019, p. 56.
[46] Ex 1, Vol 3, Tab 43, Justice Health records, Justice Health Progress Note dated 21 September 2019, p. 57.
[47]Ex 1, Vol 4, Tab 46.3, CSNSW Case Management File, HPNF dated 22 September 2019, p. 77.
[48] Ex 1, Vol 3, Tab 43, Justice Health records, Justice Health records, Letter to AMO Blacktown ED dated 21 September 2019, p. 56.
[49] Ex 1, Vol 3, Tab 43, Justice Health records, Justice Health records, Blacktown Hospital Progress Note dated 21 September 2019, p. 73.
[50] Ex 1, Vol 3, Tab 43, Justice Health records, Justice Health Progress Note dated 21 September 2019, p. 58.
[51] Ex 1, Vol 3, Tab 43, Justice Health records, Justice Health Progress Note dated 27 September 2019, p. 59; Form, p. 65.

51. On 27 October 2019, Bailey was seen by Justice Health nursing staff in a clinic, due to complaints of vomiting several times after being punched in the stomach during an altercation with another patient. He linked it mostly to anxiety. He was given Metoclopramide and his usual Mirtazapine dose. He was reported to be happy to return to the wing.[52]

52. On 30 October 2019, Bailey was transferred to Kariong CC. Mr Murrell gave evidence that Bailey's transfers from Lithgow CC and Parklea CC were due to Bailey having some association problems (with other inmates) and he was not coping with being at either centre. Bailey was transferred to Kariong CC not for the purpose of reducing risk of harm but rather that he was "*pre-positioned at Kariong so he could get to Newcastle court*".[53]

Bailey's custody at Kariong CC

53. The Kariong CC is operated by CSNSW and the medical services for inmates at that centre are provided by Justice Health. At the time of Bailey's transfer, it had capacity for 96 inmates so it is a small centre. It currently operates as a transit prison.

54. An inmate known as John Brown in this inquest had befriended Bailey in the privately managed CC when Bailey served his first sentence. At the time of Bailey's transfer to Kariong CC, John Brown was also in Kariong CC, having been transferred there some months previously. When he learned that Bailey had arrived at Kariong CC he invited Bailey to share his cell.

55. After Bailey moved in, John Brown observed that he was very unsettled and seemed unable to adjust to being back in prison. John Brown spoke with Bailey about practicing mindfulness to ease his ruminating about the past or worrying about the future. John Brown suggested that he would ask the psychologist to obtain information and Bailey said he would like that.

56. John Brown spoke to the psychologist and after learning who the material was for, she told him that Bailey was on her list to see on Monday. John Brown told Bailey this and Bailey was pleased to be able to speak to someone.[54] John Brown recalled a conversation that night where Bailey relayed a story told to him. The story was of an inmate who been on a hospital escort and had considered taking the keys from an escorting officer who had appeared asleep, but when he went to grab the keys the

[52] Ex 1, Vol 3, Tab 43, Justice Health records, Justice Health Progress Note dated 27 September 2019, p. 61.
[53] Transcript 21/10/21 T379-380.11.
[54] Transcript 3/5/21 T42.12.

officer woke up. John Brown said that he commented to Bailey that a life on the run constantly looking over your shoulder would be worse than doing your time and Bailey agreed with that.[55]

57. The following day was Saturday, 2 November 2019 and John Brown spent the day walking and talking. Bailey's mood appeared to be down. John Brown thought it might be due to withdrawals as Bailey had disclosed to him that he had (illicitly) used Suboxone (buprenorphine, an opiate substitute) prior to arriving at Kariong CC.

58. On the Sunday morning (3 November 2019), Bailey was visited by his mother Tracy and when he returned to the cell he told John Brown he enjoyed the visit and loved seeing his mum. During the afternoon Bailey was agitated so John Brown stayed with him and talked to him about fishing, surfing and motorbikes to take his mind off his worries and anxiety.

59. Later that day, after lock-in, John Brown reminded Bailey that he was seeing the psychologist the following morning. They spoke about being honest to get the most out of the session. Though Bailey had made no mention of self-harm over the preceding days, John Brown told him not to disclose any self-harm or suicidal thoughts with the psychologist as it would most likely result in Bailey being placed on a RIT.

60. John Brown explained in his evidence, "*I did say that and the reason that I said that was not because I thought that he was at risk, it was more...there's a question that they always ask when you see a psychologist in prison…they don't ask about the present…they ask "Have you ever had suicidal thoughts or thoughts of self-harm"…my commentary to Bailey was to not disclose anything from the past because I didn't feel that it would be helpful for his present situation*". Bailey indicated to John Brown that he agreed.[56]

61. On the Monday morning (4 November 2019), John Brown saw that Bailey was pacing in the yard on his own and looked depressed so told him that he had seen that the psychologist was there and that he should go to the fence to speak with her when she came out. The psychologist called out Bailey's name at about 10 to 10:30am[57] and he went with her. He was gone for over 45 minutes,[58] and when he returned, John Brown asked him how his session had been. Bailey told him that it was good and he seemed

[55] Transcript 3/5/21 T42.35-45.
[56] Transcript 3/5/21 T44.27-36.
[57] Transcript 3/5/21 T45.30.
[58] Transcript 3/5/21 T56.25-45.

relieved to have spoken to someone but that he had told her he had had "*thoughts of self-harm of [sic] suicide*" and that he was now worried about being placed in an observation cell.[59] John Brown, whilst surprised that Bailey said this to the psychologist after their previous discussion,[60] sought to reassure him that if they had real concerns Bailey would not have been placed back with the other inmates. They went back to the unit for lunch and muster. At about 12 noon, Ms Dolling came to the cell and took Bailey's cell card from the door. She called Bailey over and he left the unit with her.

Bailey's meeting with the psychologist

62. Ms Hyde was the only psychologist working at Kariong CC and at that time was working a nine day fortnight, about 7am to 3pm, Monday to Friday.[61] On 4 November 2019, she worked from 7:10 am to 4:10 pm.[62] She had no recollection of speaking with John Brown about Bailey,[63] but she explained that Bailey's name was placed on the service line by the previous psychologist who Bailey had seen.[64] According to the Offender Integrated Management System ("OIMS") records, this was psychologist Ms Jennifer Mackie who saw Bailey two months previously at Lithgow on 3 September 2019. Ms Mackie had indicated on OIMS that in her opinion Bailey required weekly sessions with a psychologist.[65] Ms Hyde explained that Ms Mackie had triaged Bailey's referral as a Psych ("P2") service line which meant that he should be seen within 12 weeks.[66] P2 means "*subacute mental health intervention service line*".[67] P1 means that the inmate should be seen again within 72 hours.[68] Each day, Ms Hyde would create a list of names referred to on the service line. Bailey was seen within the ninth week of the 12 week referral window.

63. Although Ms Hyde made no reference in her notes of that day to doing so, she said that before seeing Bailey she had reviewed his file by reading the OIMS entries of his current period in custody and she said she would have also read the OIMS from his previous period in custody.[69] She had not however sought access to information

[59] Transcript 3/5/21 T45.41-49.
[60] Transcript 3/5/21 T58.40.
[61] Transcript 4/5/21 T22.1-40.
[62] Transcript 4/5/21 T29.43.
[63] Transcript 4/5/21 T23.31.
[64] Transcript 4/5/21 T24.40 – 25.45.
[65] Ex 1, Vol 4, Tab 48, OIMS note of Jennifer Mackie dated 3 September 2019, p. 32; Tab 49, Form 3A – Psychology Participant Information Statement and Consent dated 3 September 2019.
[66] Transcript 4/5/21 T36.50.
[67] Transcript 4/5/21 T41.5-15.
[68] Transcript 4/5/21 T43.9-12.
[69] Transcript 4/5/21 T60.40-61.4; Ex 1, Vol 4, Tab 48, OIMs entries 16 July 2019-7 November 2019, pp. 28-39.

contained in his Justice Health file (which included numerous HPNFs) and agreed that accordingly on the day she was very limited in how she could discuss Bailey's risk with him.[70]

64. Although Ms Hyde was unable to recall precisely the length of time she spent with Bailey, she thought it might have been about half an hour.[71] She made handwritten notes,[72] and an entry in OIMS. She was unable to recall at what time of the day she made that entry;[73] however, a time stamp was obtained at the end of the inquest which indicates the entry was commenced at 11:55am on 4 November 2019.[74]

65. In her interview with Bailey, Ms Hyde asked Bailey to sign a form called "Psychology Participant Information Statement and Consent", by which he gave his consent to speak with a psychologist knowing that there was limited confidentiality as his information was shared within CSNSW and could be subpoenaed by outside authorities such as the police.[75] That document is distinct from an "Authority to Release Information" form providing inmate authority for CSNSW staff, such as Ms Hyde, to obtain information from a range of people (third parties).[76] The "Authority to Release Information" form is not completed routinely but rather on an "as needed" basis.[77]

66. As a result of her interview with Bailey, Ms Hyde determined that he was at risk of self-harm and that he should be removed from the accommodation unit and placed in an assessment cell. During her evidence she had little to no recall of 4 November 2019 and relied on her notes and "usual practice" in regards to how decisions and arrangements were made that day.

67. Justice Health employed a registered nurse at Kariong CC. The nurse who worked on both 4 and 5 November 2019 was RN Lara Georgiou. RN Georgiou provided a statement dated 23 April 2021.[78] She made a clinical note in Bailey's Justice Health records relating to a conversation that she had with Ms Hyde at about 11am, which indicates that Ms Hyde discussed her concerns about Bailey as she had not at that time made a decision about raising the Mandatory Notification. RN Georgiou said that Ms Hyde thought that Bailey may be okay to be in the yard during the day as he had

[70] Transcript 4/5/21 T62-63.26.
[71] Transcript 3/5/21 T27.25.
[72] Which were not kept.
[73] Transcript 4/5/21 T28.20-47.
[74] Ex 16; Transcript 22/10/21 T405.40-406.1.
[75] Transcript 4/5/21 T32.20; Ex 1, Vol 4, Tab 49, p. 3.
[76] Transcript 4/5/21 T33.7, T34.24.
[77] Transcript 4/5/21 T33.21.
[78] Ex 1, Vol 7, Tab 99.

friends and enjoyed exercise but she was concerned about Bailey ruminating at night. According to RN Georgiou, Ms Hyde said that she was unable to make those recommendations on the Mandatory Notification and that it would have to be decided by the RIT.

68. RN Georgiou's clinical note reads as follows:[79]

> *"4/11/19 – 11:00*
>
> *Nursing: Psychologist (Erin Minard) attended clinic to discuss pt [patient] - Decided to place pt on a mandatory notification due to numerous concerning factors. - Daily thoughts of suicide, sister died at 2 years old and parents coped well so they will be fine if I passed away. - See notification and psychologist notes."*[80]

69. Ms Hyde was asked questions about the process of placing an inmate on a RIT. She was referred to a document entitled "Mandatory notification for inmates at risk of suicide or self-harm". This is a seven page document which has three parts: **Part 1 Mandatory Notification** (pp. 1-2), **Part 2 Immediate Support Plan (ISP)** (p. 1 of 1), **Part 3 Risk Intervention Team (RIT) management plan** (pp. 1-2).

70. Ms Hyde referred to Part 1 as the Mandatory Notification Form ("MNF"). She said the form is required to be completed by the person who forms the view that an inmate is at risk of harm but she said that it is not part of her role to be involved in Part 2 (the Immediate Support Plan ("ISP")).[81] Ms Hyde said that the decisions involved in the ISP are made by the CSNSW officer on whatever information they have received, and that her involvement was just to provide her verbal assessment of Bailey to them.[82] Ms Hyde was unsure as to whom she provided this verbal handover as she had no memory of it, but she did record in her case notes that she spoke with three seniors.[83] On 4 November 2019, the Functional Manager was Mr Jason Asprey and the Activity Senior was Ms Dolling. The other senior (the compound senior or officer in charge) was Ms Grimshaw.[84]

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[79] Ex 1, Vol 3, Tab 43, p. 61.
[80] See also, Transcript 7/5/21 T19.41-20.4 Ms Georgiou had not seen the psychologist notes at the time she referred to them and she recalls attaching the notification to Bailey's file before leaving work that day.
[81] Transcript 4/5/21 T69.12.
[82] Transcript 4/5/21 T69.14-26.
[83] Transcript 4/5/21 T69.29-45.
[84] Transcript 4/5/21 T46.32-36.

71. Ms Hyde was taken to a 34 page CSNSW Policy document entitled "3.7 Management of Inmates at Risk of Self-harm or Suicide"[85] ("the policy") with which Ms Hyde said she was familiar.[86] However, she was not familiar with a document attached to that policy entitled "Suicide and Self-harm ISP/RIT Management Plan Reference Guide".[87]

72. Ms Hyde said her normal practice would be to speak with staff and complete the MNF, although she had no recollection of when she did so that day and she was unable to say whether she completed the OIMS before or after the MNF.[88] However, on this day, Ms Hyde, for unknown reasons, did not herself complete the MNF but rather this was completed by Ms Grimshaw and it was signed by Ms Hyde. It appears that Ms Hyde may have completed the OIMS entry before Ms Grimshaw completed the ISP as information contained in the MNF appears to have been included in the ISP. Ms Hyde said that she did not see the ISP, nor did she consider she had any role in the creation of it (even though, according to policy guidelines, it involved matters such as "*strategies for the ISP and their relevance to both level of risk and principles for least restrictive care*").[89]

73. Records indicate that Bailey was placed in the assessment cell at 12:05pm. At this time, Ms Hyde was completing her OIMS document and it would therefore appear that both the Part 1 MNF and the Part 2 ISP were yet to be commenced.

74. Ms Hyde's OIMS entry is as follows:[90]

> *"Reason for Contact: Pscyh2 SA MHI service line. Previous contact at Lithgow. Anxiety and poor coping.*
>
> *Confidentiality: Conditions of contact including limits to confidentiality explained and consent form signed.*
>
> *Presentation: 20 yo male. Looks young. Anxious and teary. Low in mood. Maintained good eye contact and engaged well. Normal rate and flow of speech. Logical and sequential in thought. Nil perceptual disturbances evident. Did not present as paranoid. Exhibited insight into his situation and poor lifestyle choices.*
>
> *Summary: Mr Mackander stated that he is "struggling". He described ongoing anxiety and depressed mood. He stated that he cries daily. He*

[85] Ex 1, Vol 5, Tab 63, Version 1.0 (34 pages). Version 1.3 is 32 pages attached to statement of T Murrell at Ex 1 Vol 7 Tab 91.
[86] Transcript 4/5/21 T56.1-12.
[87] Ex 12, Tab 15; Transcript 4/5/21 T69.49-70.5.
[88] Transcript 4/5/21 T29.3-20.
[89] Ex 1, Vol 5, Tab 63, p. 10.
[90] Ex 1, Vol 4, Tab 48, p. 36.

expressed personal responsibility for his situation and feelings of failure. He stated that he returned to drugs within 3 days of his release on parole. He reported regular ice use - started smoking but began injecting last time in custody and continued with same on release. He has also used speed and Heroin but preference for Ice. Mr Mackander reported that he would like to go to rehab and believes his solicitor is considering this as an option in sentencing.

Mr Mackander is PRLA due to drug related issues which followed him from the community. He stated he feels safe at Kariong and feels particularly supported by his cell mate [John Brown] who he knows from the community. His mother and father are both supportive however his main support person is his mother who he speaks to daily and she also visits.

Mr Mackander believes he has learning problems however has never been formally assessed. He stated he was expelled at 15 for his poor attendance and went on to complete a Carpentry apprenticeship. He did not enjoy his work and was frequently bored.

Mr Mackander reported a lengthy history of anxiety. We spent time discussing the nature of anxiety and its management which Mr Mackander expressed interest in. He is aware of a number of strategies which he is to practice. He stated that his low mood is as significant as his anxiety.

Mr Mackander reported that he thinks about suicide every day and is aware it is always an option for him. He denied having a plan although this was unconvincing. He stated that he had little to look forward to and he has little hope. He stated that there is a case conference with his solicitor on Wednesday when he will learn if rehab is an option for him or not however he believes his (drug related) charges may restrict his options. The outcome of this meeting will be particularly significant for Mr Mackander in terms of his risk of self-harm. We discussed the impact of suicide for his family, to which he stated "they will get on with things". He then told me about his 2yo half-sisters death 6 years ago to illness and reflected on how his family have got on with their life now and they would also do so if he was to die.

IMP [Impression]: Impulsive young man reporting "constant" daily suicidal ideation. Presents as hopeless and lacking future orientation. Minimising impact on family. Requires RIT.

PLAN: Discuss with F[unctional] M[anager], Activities Senior and Compound Senior. RIT activated".

75. Though the "PLAN" reads as if it is yet to occur, it is likely that Ms Hyde had completed the entry by 12:30pm and prior to commencing it she had already spoken to senior

correctional officers, as Bailey was taken to the cell whilst Ms Hyde was making the OIMS entry. It appears that the RIT was activated before the MNF and ISP forms were commenced because Ms Hyde said that recording the words "*RIT activated*" meant that she had spoken to the staff about her concerns around Bailey's risk before the Mandatory Notification was completed.[91] She thought that the ISP form was completed after she had completed her OIMS entry because the ISP includes verbatim from her case note.[92]

76. In her statement dated 23 April 2021, Ms Grimshaw said that she had a discussion with Ms Hyde at about 11:20am and at about 11:45am she accompanied Ms Dolling to collect Bailey and take him to the assessment cell. She then completed the ISP with the assistance of Ms Dolling and at 1:10pm she completed the incident report with guidance from "SCO" T (Trevor) Clarke.[93] In her evidence before the inquest, Ms Grimshaw said that the Part 1 MNF was completed in front of Ms Hyde. Ms Grimshaw said, "*I asked her the questions and she gave me the answers and I penned them…[s]itting in the senior's office"*.[94] She thought the time this occurred was shortly after 11:20am, but was not sure because she thought that Part 2 (the ISP) was completed after that and Ms Hyde had made suggestions about the protective factors in the MNF.[95]

77. The MNF signed by Ms Hyde indicated that she observed or discovered Bailey's risk of self-harm/suicide at 11:15am on 4 November 2019. The MNF refers the officer to the **"Risk factors guide interview questions".** The MNF distinguishes between whether an inmate has carried out an act of self-harm/attempted suicide or whether the inmate has threatened self-harm/attempted suicide. However, that part of the form has not been completed, nor had the part inquiring as to whether it was known whether the inmate had a suicide plan and if so, what it was. There is a box for "**[a]n inmate is assessed as at risk of self-harm/suicide (*see annexures)".** That box is ticked but there are no annexures attached such as the OIMS or any handwritten notes or a formal risk assessment document. The form then has a section, **"List any known risk factors",** under which is written:

> *"Daily thoughts of suicide, denied plan. Was unconvincing. Limited future orientation impulsive, low mood."*

[91] Transcript 4/5/21 T 47.30.
[92] Transcript 4/5/21 T 47.12.
[93] Ex 1, Vol 7, Tab 96.
[94] Transcript 19/10/21 T164.46-165.3.
[95] Transcript 19/10/21 T165.5-166.3.

78. The next section is **"what was the inmate's presentation at the time of this notification?"** under which is written:

> "*Teary, flat, anxious*".

79. The next is **"Identify any situational triggers, if known that had led to this notification"** under which is written:

> "*Charges, in custody*".

80. Finally the last section asks **"What Immediate action was taken by the First Responding officer**" and this is handwritten: "*advised FM Astbury and Productive Day K. Dolling*." The reference in Ms Hyde's note that she also spoke with "Compound Senior" appears to refer to Ms Grimshaw, who completed the MNF as well as the ISP.

81. The ISP is a single page document which refers the officer to the **"Suicide and self-harm: ISP/RIT management plan - reference guide"**. It then has a set of options relating to **Cell Placement** (normal, two-out, transition, assessment or other) and states: *"(option chosen should be least restrictive relative to risk) Note: share accommodation should not be considered as an option where a risk of harm to or from others is known to exist)*". The assessment cell box is selected. The form does not require the officer to set out any reasons for the cell selection.

82. The next item is **Clothing,** with the note *"(should be at least restrictive option relative to risk)"*. There are no set out options but Ms Grimshaw has recorded "*[n]ormal Gaol Greens*". The next item is **Restraints** and Ms Grimshaw has recorded "*[n]il*".

83. The next item is **Observations,** with options of Physical or Electronic, and whether the observations should be constant or periodic and if periodic the frequency (in minutes). Ms Grimshaw selected constant electronic observations.

84. Then, the next list is "***Diversionary activities/human interaction*** *(any immediate action required e.g phone call, provision of reading material etc)".* Ms Grimshaw has recorded "*Phone calls, reading materials, inmate mentor meeting with [John Brown]*".

85. The next item is **How will the inmate be escorted** which is not completed, except that under **Details** it is written by hand "*NIL sharps*".

86. At the end of the form there is room for the OIC who is authorising the plan to sign and date it, and lastly there is this:

"***Note: The OIC must ensure that:***

- *An initial **OIMS self-harm alert** is created and relevant information is included in the 'comments' e.g details of the mandatory notification and ISP*
- *An **OIMS IRM** is completed*
- *An **OIMS Case Note** is completed".*

87. The **OIMS IRM** number 245746 is handwritten in the dedicated field at the top of the front page of the ISP.[96] The Incident Report document 245746 indicates it was submitted for review and created at 1:25pm on 4 November 2019. The document reports that threat of self-harm was reported at 1:10pm. The document reports that the "*[p]hysc* [sic]" assessed Bailey and that at 11:30am an observation/camera cell was implemented with regards to accommodation. At the question "*What was implemented with regards to Monitoring*", the field was answered with "*24 hour observation*". At the question "*[w]hat was implemented with regards to Intervention*", the field is answered "*RIT informed*".[97]

88. Ms Hyde had no recollection of when it was that she signed the Part 1 MNF. She was asked, "*[d]o you actually have a recollection of Ms Grimshaw asking you, for example "We need to list the known risk factors. What are they?" or "What should I write?""* and she replied "*Yeah, I – not that she said exactly that but as I said, I don't have a memory – an actual memory of her filling that out but I believe it was her. So I can't really comment on exactly what the conversation was*". Though she believed that they had some conversation about filling the form in, she could not recall where that conversation occurred.[98]

89. Ms Hyde believes that she told a number of officers that she was going to raise the Mandatory Notification and believes that she spoke to Ms Grimshaw after Bailey had been taken to the cell. She said: "*because I discussed with the activities senior [CO Kelly-May Dolling], which is the senior down on the floor where I interviewed, first, in order to place Bailey in that assessment cell and then discuss with the OIC [Ms Grimshaw in the OIC office] around the paperwork and to inform her of that decision*".[99]

90. Bailey was in fact not taken to the assessment cell immediately after their interview as, according to John Brown's evidence, he was returned to the accommodation unit and later collected. This is consistent with RN Georgiou's notes that prior to 11am, Ms

[96] Ex 1, Vol 4, Tab 46.4, p. 2.
[97] Ex 1, Vol 4, Tab 46.4.
[98] Transcript 21/10//21 T321.33-45.
[99] Transcript 21/10//21 T323.40-324.20.

Hyde spoke with her about Bailey and it was at about that time that Ms Hyde decided to place Bailey on a Mandatory Notification. Accordingly, Ms Hyde, after speaking with RN Georgiou, would have spoken to the officers to inform them of her decision.

91. Ms Grimshaw said that the diversionary activities were included in the form in consultation with Ms Hyde and that Ms Grimshaw ran them by Ms Dolling to see if it was possible to facilitate them.[100]

92. Ms Hyde was asked numerous questions about her decision that Bailey should be placed on a RIT and whether she turned her mind to the policy requiring "*least restrictive options*". She was asked, "*Did you tell any of those other officers that your recommendation was for a placement assessment cell?"* and she replied, "*I don't recall my, my-my experience is that they go into an assessment cell unless we discuss other – unless I'm asked or, you know, there's some kind of discussion otherwise*". Counsel assisting asked "*there's, what a default position that they go into an assessment cell?*" and Ms Hyde said "*[y]eah. That's my experience*".[101] Ms Hyde was taken to Ms Grimshaw's statement, in which she said it was Ms Hyde who recommended an observation cell and she was asked if that was accurate and Ms Hyde replied, "*[t]hat's, that's a recommendation that I would make, yes*".[102]

93. Ms Hyde was asked some questions about her assessment of Bailey's risk. She could not recall whether there were any OIMS alerts which she had seen. She had not made a note of them in her case note on OIMS, however she said she would not in any event. She said that she did not look at Bailey's CSNSW case management file in relation to previous HPNFs, although she could have accessed it.[103]

94. Ms Hyde was not aware of a Justice Health Mental Health Triage form dated 6 August 2019 that indicated Bailey had been diagnosed with generalised anxiety, panic attacks and had been started on anti-depressants.[104] Ms Hyde conceded that in compliance with the CSNSW policy to carry out her risk assessment, she should have accessed that material and failed to do so.[105] She conceded that it would have helped

[100] Transcript 19/10/21 T167.50-168.10.
[101] Transcript 4/5/21 T50.45-51.6. See also Transcript 6/5/21 T4.1-10, Mr Cargill agrees at first instance he would go into one of those two safe cells.
[102] Transcript 4/5/21 T53.25.
[103] Transcript 4/5/21 T58.12-20.
[104] Transcript 4/5/21 T59.20-30.
[105] Transcript 4/5/21 T63.12.

her to understand more about Bailey's situation on the day and she was limited in how she could discuss Bailey's risk with him.[106]

95. Ms Hyde was taken to the point in the policy relating to taking into account information gathered from contact with family or external service providers when carrying out a risk assessment.[107] She agreed it could have been useful to speak to Bailey's mother and it could have been useful in assisting Bailey in dealing with her recommendation that he go into an assessment cell.[108]

96. Ms Hyde said that she was in position to seek and obtain Bailey's consent to speak to his mother but she did not do so, and she was not sure why she did not.[109] Even later that afternoon when an "admin" person telephoned Ms Hyde saying that Bailey's mother was on the phone wanting to speak about Bailey, Ms Hyde declined to take the call and told "admin" to pass on the message that "*her loved one is in safe hands*". She told "admin" that she did not have Bailey's consent to speak to his mother. In response to counsel assisting's questions, Ms Hyde was unable to explain why, knowing that Bailey's mother wanted to speak with her, she did not attend the cell to obtain Bailey's consent to speak with his mother.[110]

97. Ms Hyde was taken to the policy which states:[111]

> "*Placing an inmate into an assessment cell is a measure of last resort and should not be used routinely. 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 (under an ISP or RIT plan) without the written approval of the Governor.*
>
> *When an assessment cell is used the ISP must specify the … length of time the inmate will stay in the cell … frequency of human interaction … diversionary activities … details of items issued …. [and] observation monitoring schedule...".*

98. Ms Hyde said that she did not give any guidance about those matters to Ms Grimshaw or any other officer and agreed that she should have done so as the psychologist who made the recommendation that Bailey be in the assessment cell. She was unable to

[106] Transcript 4/5/21 T63.16-26.
[107] Transcript 4/5/21 T63.30 (p. 7 of the policy at Ex 1, Vol 5, Tab 63).
[108] Transcript 4/5/21 T63.35-50.
[109] Transcript 4/5/21 T65.15-22.
[110] Transcript 4/5/21 T64.40-66.21.
[111] Transcript 4/5/21 T66.46 (pp. 11-12 of the policy at Ex 1, Vol 5, Tab 63).

explain why she did not.[112] Contrary to Ms Grimshaw's evidence, Ms Hyde said she did not see the ISP and had no role in it.[113]

99. Ms Hyde was asked questions directed at considering least restrictive care options, such as Bailey being in a cell with John Brown during the day. Though she did not speak to Bailey or John Brown to discuss this option with them, she said that she thought that he was such a risk of harm that the only safe place for him was to be in an observation cell.

100. Ms Hyde was asked if it was her "*normal practice to talk to officers about the implementation of an ISP for an inmate in an assessment cell*" to which she said, "*[s]o as in would I come back later and … Look Kariong's a very small centre. So, you know we're in a – in a good position in that we're, we're in and out of the compound all day so you, you do see, you know, what plans have been put in place*". She was asked, "*[d]id you consider it part of your professional responsibility once this ISP had been completed to engage with any other officers about how it would be implemented?*" to which she replied "*[n]o*".[114]

101. Shortly after Bailey was placed in the assessment cell, he made numerous requests to speak with the psychologist. Ms Hyde's evidence was that she had no recollection of Bailey making any such request and that she would have expected to be informed about any distress he experienced during the day. Transcripts of the calls at 12:45pm, 12:58pm and 1:01pm were read out to her and she said that information was not passed on to her, but that she expected that information such as that would have been. Ms Hyde said that had she been so aware, she would have gone to speak with Bailey or had him brought to her office to speak with him.[115]

102. After the inquest resumed in October 2021, Ms Grimshaw gave evidence that she did not ask Ms Hyde to see Bailey because Ms Hyde was in her office at the time when Bailey was speaking over the intercom and Ms Hyde said to her that she was not going to speak to him. Ms Hyde was recalled as a witness so that this evidence could be put to her and she denied ever hearing Bailey over the intercom when she was in Ms Grimshaw's office.

103. Ms Hyde agreed with counsel assisting that it was reasonable to consider that she was in Ms Grimshaw's office at around midday based on Bailey being interviewed at about

[112] Transcript 4/5/21 T67.5-20.
[113] Transcript 4/5/21 T68.35-69.1.
[114] Transcript 4/5/21 T54.1-16.
[115] Transcript 5/5/21 T10.10-11.29.

11am for 45 minutes.[116] However, that time may not be accurate, particularly given RN Georgiou's note that it was 11am when she and Ms Hyde discussed Ms Hyde's consideration of raising the Mandatory Notification. Ms Mahony, on behalf of CSNSW, submits that the OIMS case note time of 11:55am[117] establishes that Ms Hyde was in her own office[118] at that time completing the OIMS case notes. That is correct; however, it would not have taken more than 30 minutes and given other evidence referred to, Ms Hyde could well have been in Ms Grimshaw's office at around 12:45pm.

104. Ms Hyde gave evidence that she had completed "*hundreds*" of MNFs but was unable to provide a reason that she signed rather than filled out the form on this occasion. In response to questioning from counsel assisting, she replied, "*I can only assume that it would have been to – that we did it, in a sense, together. So I was with her as she filled that out, and I signed it*".[119]

105. Ms Grimshaw said in her statement that she thought she had finished the ISP at about 12:45pm but it is unclear if Ms Hyde was with her at that time. Ms Grimshaw said that she asked Ms Hyde why she would not see Bailey and that Ms Hyde replied that she believed it would escalate Bailey too much.[120] Ms Hyde denied that she had heard Bailey yelling from the assessment cell while sitting in Ms Grimshaw's office. She denied telling Ms Grimshaw "*I don't want to see him*".[121]

106. Ms Hyde denied refusing to see Bailey and on numerous occasions throughout her evidence she sought to explain why she would not see an inmate in an assessment cell. That was clarified in this exchange with Ms Lewer:

> "*So the main reason for that is in my experience they do escalate, because I actually have no - as a psychologist, once you've raised a mandatory so that mandatory is related to the assessment that you've just made around risk. You don't change that assessment until - so the next assessment is by the team that will review that risk, as I said, the following day generally, so I actually can't do anything about the assessment cell or the conditions that they're in, unfortunately, so generally I find that they escalate if I engage in that conversation, which is unhelpful, but the staff are able to provide that information around the process*".[122]

[116] Transcript 21/10//21 T324.35-40.
[117] Ex 16.
[118] Ms Hyde was in her office when she completed the OIMS: Transcript 21/10/21 T326.5-10.
[119] Transcript 21/10//21 T325.40-45.
[120] Transcript 19/10/21 T 182.24-31.
[121] Transcript 21/10//21 T329.46.
[122] Transcript 21/10/21 T333.4-15.

107. The last exchange with Ms Lewer regarding whether it was possible that Ms Hyde refused to see Bailey was this:

> "Q. *If the information was conveyed to you that Bailey wanted to talk about why he was in the safe cell, in those circumstances, you might have refused to see him. Is that fair?*
>
> *A. Yeah. I don't like the - I don't like the use of that word "refusing to see him". It's just not appropriate to see him in that - for that reason, at that moment, when he's just been placed in that cell. But I don't have a memory of that, but certainly it's possible*."[123]

108. Ms Hyde said that the CICs on 4 November 2019 at 12:45pm, 12:58pm and 1:01pm indicated that Bailey was having a panic attack and that would be a reason (had she known) that Bailey would have been seen.[124]

109. In my view, Ms Hyde's evidence was given with the benefit of hindsight. It is likely that Ms Hyde heard Bailey during these times, however considered that he wanted to see her only to argue that he should be removed from the observation cell. It may not have been apparent to Ms Hyde at that time that Bailey was genuinely having a panic attack.

110. Ms Grimshaw said that in the afternoon, Ms Hyde came to her office and told her that Bailey's mother had called but that Ms Hyde did not speak to his mother. When this was put to Ms Hyde, she denied doing so, saying "*[t]here would be no reason for me to tell her that*".[125] I accept that Ms Hyde did tell Ms Grimshaw this information. Ms Hyde could provide no good reason as to why she did not speak to Bailey's mother. If it was because she did not have Bailey's consent, she could easily have gained that by attending his cell. It is unlikely her attendance for such purpose would have escalated Bailey, especially as at that time he had just spoken to his mother. In any event, Ms Hyde did not proffer that as a reason as to why she did not obtain his consent. On balance, the reason seems to be that she had no intention of speaking with Tracy so there would be no purpose in obtaining his consent to do so.

111. Ms Hyde knew that Tracy was Bailey's main support person, that Tracy would have been concerned about Bailey and that she could have obtained useful information from Tracy about Bailey. Ultimately, it would also have been most appropriate and courteous to take the telephone call and at least listen to what Tracy wanted to speak to her about.

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[123] Transcript 21/10/21 T335.10-18.
[124] Transcript 21/10/21 T335.20-33.
[125] Transcript 21/10/21 T336.31-24.

112. Throughout her evidence, it was Ms Hyde's position that although she had identified that Bailey was at risk of self-harm and she technically raised the Mandatory Notification, it was her belief that it was up to the correctional officers to manage Bailey in the cell and this included any engagement with his family. Further, Ms Hyde, despite having previously completed "*hundreds of MNFs*", was unable to explain why she did not complete the form on this day, leaving it up to Ms Grimshaw to do so.

113. I was unconvinced by Ms Hyde's evidence that she was not aware that Bailey was not coping in the cell (from the time he was put in it, until he became settled upon speaking with his mother and hearing her undertaking to speak with someone about the situation). As Ms Hyde said, Kariong CC was a small centre.[126] Ms Hyde clearly went up to Ms Grimshaw's office, at least to sign the MNF (which was completed after Bailey was placed in the cell and after Ms Hyde had completed her OIMS entry) and later to tell Ms Grimshaw at around 2:30pm that she had declined to speak to Bailey's mother. Ms Mahony's submissions prefer that the MNF was completed before Bailey was placed in the cell, but I think that is incorrect.

114. Ms Hyde's evidence made it clear that she had little to no memory of the events of the day, whereas Ms Grimshaw did. Ms Grimshaw's evidence that Ms Hyde was in front of her as she penned the MNF which she thought she completed at 12:45pm was compelling, as was her apparent honest recollection when giving evidence that Ms Hyde was sitting in front of her when Bailey was yelling and said that she was not going to see him. Ms Grimshaw said that asked Ms Hyde she would not see Bailey to which, according to Ms Grimshaw, Ms Hyde replied that she did not want to escalate him/ This is consistent with Ms Hyde's explanation in evidence as to why she would not see an inmate in an assessment cell.

115. It would appear that when Bailey was advised he was being placed in the assessment cell and taken to it, he asked to speak with the psychologist because his first CIC was at 12:05pm and he says, "*Miss can I please speak to the counsel lady like you promised me?*"[127] Ms Hyde was in her office in a different building at that time completing the OIMS case note which she commenced at 11:55am. It is likely that it was after that time that she attended Ms Grimshaw's office to sign the MNF which had yet to be started. The IRM was completed at 1:25pm and indicates that the incident regarding self-harm was reported at 1:10pm. The time of 1:30pm is consistent with it

[126] At that time there was capacity for 96 prisoners: Ex 1, Vol 7, Tab 93, Statement of Peter Cargill dated 18 April 2021, [6].
[127] Ex 10, p. 1, 12:05:54, Item #1- File name: Call 1205; Ex 12, Tab 16, p. 1.

being by that this time that both the MNF and ISP had been completed (on the basis that the MNF was penned while Ms Hyde was in Ms Grimshaw's office, as it was in fact around 11:20am when Ms Hyde verbally reported Bailey as at risk of self-harm).

116. I note that at 1:05pm, Ms Grimshaw told Bailey that the Functional Manager was coming to see him. This is consistent with it being a correctional officer who would be able to facilitate Bailey engaging in diversionary activities, rather than Ms Hyde attending (despite numerous and frequent requests by Bailey from 12:05pm to see the psychologist). Consistent with Bailey being with John Brown, there are no further CICs until 1:53pm, and in that CIC Ms Grimshaw told Bailey that the psychologist had gone home.[128] It was then that a phone call was facilitated for Bailey to call his mother.

117. Ms Grimshaw said that it was Ms Hyde who had made suggestions to her as to what diversionary activities Bailey might have, and that they are contained in the ISP. This engagement is denied by Ms Hyde, however I prefer the recollection of Ms Grimshaw in that regard. She certainly had never completed either a MNF or ISP before and required guidance.

118. Ms Grimshaw said in her statement that she also received guidance from Ms Dolling. However, Ms Grimshaw said in her oral evidence that this was after she and Ms Hyde had completed the ISP, explaining: "*Because I wasn't confident in my abilities I just wanted to check with her after I filled that out with Ms Dolling to make sure that [John Brown] was a suitable replacement for an Aboriginal delegate and if I could give him a phone call and how that phone call had to be done*".[129] I have no doubt that it was Ms Hyde who suggested to Ms Grimshaw that John Brown might assist settling Bailey. On the basis that the MNF and ISP were completed at the same time and likely finished by 1:10pm, Ms Hyde was in Ms Grimshaw's office by at least 12:45pm. I do not accept Ms Hyde's denials that she did not hear Bailey yelling. I do not accept her denials that she was unaware that Bailey was requesting to see her. I do think she told Ms Grimshaw that she did not want to see Bailey for fear of escalating him or at least hoping that he would settle down once the diversions were actioned.

119. It would appear that Bailey's escalation in the cell on 4 November 2019 was not brought to the attention of RN Georgiou at any time that day. She said that she attended Bailey at about 4pm and gave him his medication and he appeared calm and settled and he did not raise any issues with her. She made a clinical note to this effect

[128] Ex 10, pp. 6-7, 13:05:49. Item #22- File name: Call 1305; 13:53:48, Item #23 - File name: Call 1353.
[129] Transcript 19/10/21 T193.4-8.

in his file.[130] However, given that she was aware that Bailey's cell placement had changed and that Bailey was on a RIT she should have, in accordance with Justice Health policy, completed a HPNF. She said that although it was a key document that should have accompanied the MNF, she did not complete an HPNF due to (a lack of) resources as it was a very busy day.[131]

120. There is a concerning lack of time stamps on the documentation kept by CSNSW in relation to inmates who are placed on a RIT and for inmates who are in an assessment cell. Although their containment is recorded and although there is a digital record of any CICs made, there is no requirement to record any of those matters on any document to inform the RIT review team or to inform decisions about the appropriate management of an inmate in an assessment cell.

121. This lack of documentation and process has demonstrated the need for recommendations to be made in relation to documentation involved in the RIT process, and is discussed further at [196] to [249] in relation to the RIT review process.

Bailey's experience in Cell 41 on 4 November 2019

122. Though Bailey was in the assessment cell for observation, there were no instructions provided to any correctional officer about the frequency with which observations should be made and what matters should be noted. There is no contemporaneous log of the times of the CICs, there are no notes of the content of the CICs (or even a synopsis of them), there are no records or notes of any of Bailey's distress, behaviour or any of the activities and interventions Bailey was engaged in, and there are no notes of Bailey's health whilst he was in the assessment cell. I note COPP3.7 at Policy 4.6 states:

> "*All observations conducted are to be recorded on a ISP/RIT Management Plan-Observation record. Observations are useful both for keeping the inmate safe and for gathering information to inform the development of future plans to manage the inmate's risk*".[132]

123. Other than one OIMS entry made that evening when Bailey was escorted to hospital with chest pains, there are no entries in OIMS about his time in the assessment cell to which any member of the RIT review team could refer when they came to conduct the review on 5 November 2019.

[130] Ex 1, Vol 3, Tab 43, p. 62.
[131] Transcript 7/5/21 T50.25-51.55.
[132] Ex 1, Vol 5, Tab 63, Version 1.0 (34 pages). Version 1.3 is 32 pages attached to statement of T Murrell at Ex 1 Vol 7 Tab 91.

124. CSNSW does have digital records with time stamps for all the CICs and the audio recordings of the CICs as well as the video recordings of the cell. This material was made available to the coronial investigation and tendered in the inquest together with transcripts of the CICs. However, these recordings were not accessed, considered or referred to by the RIT review team on 4 November 2019. A timeline of the events in the cell on 5 November 2019 (before Bailey was transferred to hospital) was prepared by Bailey's family's representative and tendered into evidence.[133]

125. These records show that on 4 November 2019, Bailey made 67 CICs between 12:05pm and 1:54pm.[134] There are 23 incidents of conversations between Bailey and mainly Ms Grimshaw where he is clearly distressed, asking to the see the psychologist and saying he cannot breathe.

126. Ms Grimshaw in her statement describes that between the time that Bailey was placed in the assessment cell at 11:50am and 3:30pm, "*[his] demeanour alternated, at times appearing to be one of or a combination of crying, angry, anxious, difficult to placate, to other times appearing calm and happy*". She said that she facilitated John Brown to be with Bailey between 1pm and 2pm, that Bailey had a telephone call at about 2pm, "*at [2:20pm] he appeared happy and calm*" and that Bailey and John Brown moved back to the assessment cell. John Brown returned to his unit at 3pm and gave Ms Grimshaw a book and a drink sachet to give to Bailey (which she did). Ms Grimshaw said that at about 3:30pm, Bailey was quietly reading in the cell and she finished her shift.[135]

127. Ms Grimshaw said in her statement that during that time she had various interactions with Bailey, trying to ascertain the reason for his disquiet, explaining her duty of care to Bailey and the reasons and processes for the ISP, reassuring Bailey, discussing possible diversionary activities, coping techniques, "*distraction conversation*", positive goal setting, encouraging positive behaviour and positive reinforcement.

128. In her evidence she was taken to the transcripts[136] of the content of numerous CIC exchanges between herself and Bailey.

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[133] Ex 22 – see FN 124.
[134] Ex 1, Vol 4, Tab 46.28 is the primary document of all CIC records at Kariong (from 3/11/19 at 04:23:24-6/11/19 at 15:41:27). Also see, Ex 12, Tab 16; Exhibit 10.
[135] Ex 1, Vol 7, Tab 96, [10]-[17].
[136] Transcripts of the CICs from Cell 41 were initially tabulated in the "CSNSW Serious Incident Report Death in Custody 6 November 2020" (see Ex 1, Vol 4, Tab 46, pp. 12-21). Those assisting the coroner and/or the family's representatives tabulated CICs for 4 and 5 November 2019 (Ex 4 for selected calls on 4 and 5 November 2019; Ex 10 for all calls on 4 November; Ex 11 for all calls on 5 November 2019 (this supersedes the version at Ex 1,

129. At 12:22.55pm, Bailey said that he could not be in the cell any longer and was in fear for his own safety. Ms Grimshaw told him "*you're on a RIT, that RIT can't be undone, you're gonna have to just calm down and figure it out*."[137] At 12:43pm, after Bailey again pleaded that he wanted to get out of the cell, Ms Grimshaw said, "*Bailey. You need to listen. I've already explained this to you. You can't be processed until tomorrow morning. So you can't be let out until tomorrow morning…it's non-negotiable*".[138] Ms Grimshaw said in her evidence that she was of the belief that she could escalate a RIT but could not de-escalate or remove it.[139]

130. This demonstrates a fundamental misunderstanding as to the policy that "*[t]he ISP can be reviewed and updated until such time as a RIT convenes (correctional centre only) and conducts an assessment and formulates a RIT management plan*".[140] Another fundamental misunderstanding was that a RIT necessitated an assessment cell. It was described by Ms Hyde as the "default" position at Kariong CC. Ms Grimshaw said she relied on Ms Hyde's advice that Bailey be placed in an assessment cell, rather than exercise her mind as to the least restrictive care requirement, as she had not carried out any assessment of Bailey.

131. Bailey asked to see the psychologist at 12:05pm. Officer John Jentsch, who was apparently watching the CCTV monitor, called Bailey and told him to take a seat and calm down. Bailey called at 12:09pm saying, "*Chief please*" and Ms Grimshaw told him that everything had been explained to him and he needed to take action. At 12:11pm, Bailey called saying, *"there's gotta be something you can do. I cannot be in here. It's fucking making me feel sick. I'm gonna have an anxiety attack. Please!*" He was again told to sit down, take some deep breaths and just relax. At 12:17pm, Bailey called twice and asked for the counsellor to come and see him. He asked to be let go, said he needed to get out and said "*I'm gonna have a … panic attack".*[141]

Vol 5, Tab 53 but there is no material difference to Ex 11). CSNSW provided to the inquest a further table of all calls on 4 and 5 November 2019 which includes at times the names of some of the Correctional Officers engaged in those calls (Ex 12, Tab 16). The audio recordings of all Cell 41 CICs on 4 and 5 November 2019 from which the transcripts were created are at Ex 4A and Ex 1, Vol 5, Tab 53. The CCTV footage of Cell 41 on 4 and 5 November 2019 was provided to all parties but was not tendered into evidence; however 17 short clips from within that footage were tendered (Ex 5 contains CCTV clips of 4 November 2019 and Ex 8 contains CCTV clips of 5 November 2019). The CCTV footage has been viewed in association with listening to the audio of the CICs. Ex 22 is a tabulated record and description of movements on 5 November 2019 prepared by representatives of Bailey's family.

[137] Ex 10, 12:22:55, Item #13 – File name: Call 1222; Ex 12, Tab 16, p. 1.

[138] Ex 10, 12;43:12, Item #16 – File name: Call 1243; Ex 12, Tab 16, p. 3.

[139] Transcript 19/10/21 T181.3.

[140] Ex 1, Vol 5, Tab 63, Part 4.1 at p. 9 and definition of ISP at p. 32.

[141] Ex 10, pp. 1-2; Ex 12, Tab 16, p. 1.

132. Two minutes later at 12:19pm, Bailey asked to be let out and said that he was not coping. Ms Grimshaw told him that he was bringing unwarranted attention to himself (because inmates in another accommodation unit would be able to hear him yelling). Bailey next had an exchange via a CIC with Ms Grimshaw between 12:21pm and 12:23pm where he asked for help, saying that he could not be in the cell anymore. She told him that the RIT could not be undone (as per [129] above) and he needed to calm down. Bailey told her he could not and Ms Grimshaw told him that he was "*proving the reason as to why you were put on the RIT in the first place by behaving like this*".[142]

133. Bailey made nine further CICs but these were apparently not answered. The next CIC was at 12:43pm was instigated by Ms Grimshaw, asking Bailey how he was going and if he was a little bit calmer. He said that he wanted to get out and that "*I'm not calm at all*". Ms Grimshaw said that she was prepared to talk to him but he could not keep telling her he wanted to get out of the cell because it could not change anything. He told her the cell was not good for his mental state; he asked her to understand where he was coming from, that he was having a panic attack and the cell was making him sick.[143]

134. When Bailey's voice became elevated, Ms Grimshaw told him that she would talk with him but not if he was doing the "*shouty shouty thing",* a term she used twice during the CIC. When Bailey told her, "*I can't cope in here. Please do something. I can't cope*" she replied, "*[w]ell I was going to let you out for a phone call so you could have a discussion with Mum, but I can't while you're doing this*". Bailey then started crying and sobbing and saying "*I want to get out of this cell*", he said that he was fine to be [in the cell] with John Brown and that he has "*never wanted to self-harm in my life*". He pleaded for her to let him out, saying it was torture.[144] Ms Grimshaw accepted when giving evidence that the way she spoke to Bailey was inappropriate.

135. The ISP was not completed until after this 12:43pm CIC. Regarding the issues as to whether Ms Hyde was aware of Bailey's distress and his requests to see the psychologist, I note that two of the diversionary activities entered on the ISP were a telephone call and a visit by John Brown. Ms Grimshaw was unable to specify which of the three diversionary activities on the ISP were specifically suggested by Ms Hyde.

136. As already indicated at [129], Ms Grimshaw then told Bailey that he could not be let out of the cell until he was processed the following day and it was non-negotiable. She told

[142] Ex 10, pp. 2-3; Ex 12, Tab 16, pp. 1-2.
[143] Ex 10, pp. 3-5; Ex 12, Tab 16, pp. 2-4.
[144] Ex 10, pp. 3-5; Ex 12, Tab 16, pp. 2-4.

him that it was not torture and if she was in gaol, the assessment cell is where she would want to be. He told her he was not "*mental*" and he needed to be out of the cell but Ms Grimshaw told him, "*I'd like you to have a normal conversation with me rather than this shouty, demand let–me-out.*" He told her he was stressed, panicking, feeling sick and could not cope. She told him, "*[y]ou can cope and you will cope*". At this point, Bailey asked Ms Grimshaw, "*[p]lease. Can't you get the counsellor to come and see me please*". Ms Grimshaw told Bailey he could do this easily. Bailey told her he was sick and that he could not breathe. Ms Grimshaw told Bailey that he could not breathe because he was winding himself up, that he was smarter and stronger "*than this*" and told him to "*get it together*". Bailey then said "*why … would you do this to someone... this is not right, get me out of here. Please, or get the counsellor so I can speak…"*[145] Ms Grimshaw did not answer. Bailey called again, and again there was no answer.

137. At 12:58pm, Bailey called and said, *"please you cannot fucking do this to me…. You cannot … put me in this…. Get me outta here. Get me out. Or call the fucken counsellor or the psychologist that put…*" Ms Grimshaw replied, "*I'll put you on a full RIT and take you greens*". *[146]* This meant that if Bailey continued to make demands he would have his regular clothes taken from him. In her evidence Ms Grimshaw said that she had not intended those words to be a threat.[147] In her evidence, Ms Grimshaw acknowledged the inappropriateness of some of her wording and said that by this stage she was panicking about what to do.

138. Bailey continued to make CICs from 1pm which were not answered, in which he repeated all that he had previously said, such as that he was not coping, to call the psychologist, that he had never self-harmed in his life ever and never will, to call the ambulance, that he cannot do this, please help, to call the "*psych*". He repeatedly asked "*please", "somebody help*" and he said, "*I can't breathe*".[148]

139. Ms Grimshaw did answer the 1:05pm CIC and told Bailey that he had to stop, that he was safe and that the FM (Functional Manager) was coming to see him.[149] John Brown wrote in his notes that at about 1:30pm on 4 November 2019, Mr Clarke (the Intel Supervisor) asked him if would be willing to go to the safe cell to sit with Bailey and try to calm him down. Mr Clarke told John Brown that Bailey was beyond distraught and that his behaviour was such that if it continued to spiral downwards he would face

[145] This was at 12:51pm but seems to be a continuation of the 12:43pm CIC (Ex 10, pp. 3-5; Ex 12, Tab 16, pp. 2-4).
[146] Ex 10, p. 5; Ex 12, Tab 16, p. 4.
[147] T19/10/21 T181.11-17.
[148] Ex 10, pp. 6-7; Ex 12, Tab 16, pp. 4-5.
[149] Ex 10, p. 6; Ex 12, Tab 16, p. 5.

further sanctions. The term "*sanctions*" was John Brown's and he agreed with Ms Mahony that he used that term in his notes because moving from a general cell to an observation cell may feel like a sanction.[150] John Brown agreed to visit Bailey.

140. John Brown wrote:

> "*When I entered the safe-cell, Bailey was pacing and was in tears and very clearly emotional. I hugged him and sat on one of the beds. I asked him why he was so distraught and he told me that he was terrified of being alone in the cell. I asked him why he was terrified and he said it felt to him like he was in a horror movie like Saw*."[151]

141. John Brown said that he was in the cell with Bailey for about one and a half hours. He said that for the first hour, Bailey was inconsolable. After being in the cell with Bailey for about 30 minutes, Bailey made a CIC and pleaded to be taken off the RIT. The only CIC set out in the transcripts is at 1:53.48pm. In this call, Bailey spoke with Ms Grimshaw and asked if the psychologist was still there and Ms Grimshaw told him that she had gone home. In her evidence, Ms Grimshaw said that at the time she told Bailey this she believed that Ms Hyde had left the centre; however, she learned that this was incorrect when she saw Ms Hyde at around 2:30pm after Tracy had sought to speak with Ms Hyde on the telephone.

142. John Brown said in his notes that shortly after Bailey had made the CIC, Mr Cargill came to the safe cell and he quietly and calmly spoke with Bailey, explaining to him that "*he would need to show that he could do one night quietly and calmly in the safe-cell and if everything went well, he would be assessed at 8 am next morning and returned to the unit. Bailey continued to state that he was afraid of being alone in the cell*".[152] John Brown asked Mr Cargill if he could stay overnight in the cell with Bailey but Mr Cargill said that was not possible. Mr Cargill then left the cell.

143. According to John Brown, when he and Bailey were in cell 41 together, Bailey told him he would fake an illness to go to hospital. John Brown asked him what he thought he would achieve by doing so and Bailey told him that it would get him out of the safe cell. John Brown replied that he would be returned to that cell and it would most likely ruin any chance of being taken off the RIT the next morning and could mean that he stayed on the RIT for a week.

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[150] Transcript 3/5/21 T59.1-14.
[151] Ex 1, Vol 6, Tab 76, pp. 8-9.
[152] Ex 1, Vol 6, Tab 76, p. 9.

144. According to John Brown, Ms Grimshaw then attended the cell and repeated what Mr Cargill had said, reassuring Bailey that he would be assessed at 8am the next day and that "*things were being done for him that wouldn't normally be done for other inmates in his situation*"[153]. Bailey asked if could make a telephone call. Ms Grimshaw agreed and John Brown and Bailey went to the accommodation unit 2 where Bailey telephoned his mother.

145. Given that this was Tracy Mackander's last time that she spoke with Bailey, she would prefer to keep as much of this this call as private as possible so I will be brief with the matters significantly relevant in the inquest. I note that SCO Clark, who was Intel Supervisor on 6 November 2019, listened to the recording of the telephone call between Bailey and his mum and made a report of the same date.[154] The call commenced at 2:07pm on 4 November 2019. SCO Clark reported that:[155]

> "*During this call inmate Mackander sounds distressed due to his current placement on a Mandatory Notification. He states he cannot deal with it. The receiver of the call was supportive of him, saying he needs to calm down and he would not have been put in observation cell for no reason. He admitted to having thoughts of self-harm but said he would not carry them out. He also stated he was having panic and anxiety attacks. The receiver of the call stated that she would call the centre and find out what was happening*".

146. The relevant conversation between Bailey and Tracy included Bailey saying, "*I spoke to a counsellor today. And I said a few things and I just said how I was feeling. And they put me in a RIT cell*". Tracy said to Bailey, "*[d]id you tell them that you wanted to kill yourself or something*" and he said, " *I know I said that the thought goes through my head, like every other inmate in here …I said, but doing it is a different story ... and then I open up to her and I get this shit happening to me…they keep me there for the night and assess me tomorrow…I can't even be in there for 2 seconds…they brought [John Brown] down to talk to me but it's still not working*". Tracy said, "*they'll only keep you there for 24 hours. They can't keep you there any longer than that, can they*?". Bailey replied, "*[t]hey can keep me in there for a week if they wanna kick [keep] me for a loop. And do you know what she said in the notes, because I was upset. That's why. They're fucked up…I never said I wanted to kill myself, ever, ever. I said it goes*

[153] Ex 1, Vol 6, Tab 76, p. 10.
[154] Ex 1 Vol 4 Tab 46.8. A transcript of the call; Ex 1, Vol 5, Tab 51.
[155] Ex 1, Vol 4, Tab 46.8.

through my mind like every other person in the gaol, I said but doing it is another thing. And it's on my record, I've never ever self-harmed in my life, ever".[156]

147. Tracy told Bailey that she would ring the centre and that they could not keep him in there, and that it was only an observation thing. He told her "*[t]hey can; I've known people who have been in there for months, weeks…I'm gonna have a panic and anxiety attack. I fucking can't do it. I can't relax...I can hardly breathe…literally - I can hardly breathe*". Tracy suggested that he do exercises like star-jumps and push-ups and be active in the cell and he responded, "*[t]hey'll think I'm even more fucking mental*…".[157]

148. After the phone call, which was a little over six and a half minutes, Bailey and John Brown returned to Cell 41. Tracy called the centre and when Ms Hyde refused to speak with her she rang a client liaison officer (at Long Bay CC), who said she would send a consent form to Bailey for him to sign.

149. John Brown wrote in his notes that after Bailey's phone call with his mother, Bailey seemed to have calmed down. John Brown reminded Bailey to be compliant and he would only be in the cell for one night. He asked Bailey if he wanted anything and Bailey asked for a book and an Orange Tang drink, which John Brown delivered to Ms Grimshaw (who in turn gave the items to Bailey).

150. Ms Grimshaw notes that at about 3:30pm, Bailey was quietly reading his book. She then left the compound, leaving Mr Cargill in charge. As there had been an overlap in shifts, Mr Cargill was able to see Bailey and no doubt had a handover about the events of the day before Ms Grimshaw left.

151. Mr Cargill said in his evidence that he started his shift at 1:20pm on 4 November 2019, even though his shift was from 2pm to 10pm,[158] and that everyone else who worked through the day left the compound by 4pm[159].

152. RN Georgiou left at about the same time. She noted that Bailey was settled and calm. This is consistent with Bailey having been upset for the first one and a half hours in the cell, and the diversionary activities (of John Brown visiting, speaking with Tracy, knowing that she was going to call the centre and being given the book) having the desired effect. Bailey was in fact calm and settled for this time (for a short time at

[156] Ex 1, Vol 5, tab 51.
[157] Ex 1, Vol 5, tab 51.
[158] Transcript 5/5/21 T87.20-27.
[159] Transcript 5/5/21 T88.23.

least). This changed shortly after 4pm when Bailey made a CIC complaining of chest pain. He was shortly thereafter transferred to hospital for investigation.

153. Mr Cargill had no memory of this earlier part of his shift and set out his recollections in his statement dated 18 April 2021, under the heading "*My recollections of my interactions with Mr Mackander … on 4 and 5 November 2019 …*". The only matters he addressed in relation to 4 November 2019 were that he had commenced his shift at 1:20pm and on the shift he escorted Bailey from Door 13 of the accommodation building to the ambulance to be taken to the Hospital for a pain to his neck and shoulders. He escorted Bailey back towards Door 13 upon Bailey's return.[160]

154. Notes made by Ms Dolling on 5 November 2019 (provided to Mr Cargill on that date) refer to Bailey attending hospital "*yesterday*". Those notes indicate that Bailey went to hospital at 5:15 pm and returned at 6:45 pm and that the probable diagnosis was a panic attack.[161] The CIC was made by Bailey at 4:08pm, however there is no transcript of it.[162]

155. There are no CSNSW witness statements as to the events leading to Bailey attending the Hospital on 4 November 2019. There is an OIMS case note entry written by Mr Cargill:

> "*Inmate MACKANDER was taken to Gosford Hospital in the afternoon of Monday 4th November 2019 by ambulance after complaining of chest pain. He was treated and returned to Cell 41. His discharge letter indicates that he is well. According to medical staff it is possible he was suffering from anxiety. I interacted positively with him upon his return. He did use the intercom to request his TV be turned down and he went to sleep shortly after. He had been reassured that his RIT status will be reviewed in the morning*".[163]

156. Mr Cargill recorded on the OIMS the IRM 245790. He also completed that IRM.[164] He recorded on 4 November 2019 at 6:31pm:

> "*16:15hrs … [Bailey] activated Cell intercom and complained of chest pain. Ambulance was called and Ambulance officers McMillan and Hemmings attended at 16:30. Inmate transported to Gosford Hospital 17:15. Inmate is due to return shortly*."[165]

[160] Ex 1, Vol 7, Tab 93, [8]-[9].
[161] Ex 7.
[162] Ex 4, Tab 46.28 indicates the activation of Cell 41 CIC at 16:08:16-16:08:55.
[163] Ex 1, Vol 4 Tab 46.17, p. 37.
[164] Ex 1, Vol 4 Tab 46.5, p. 1.
[165] Ex 1, Vol 4, Tab 46.5..

157. Following that entry, there is a date of 4 November 2019 and a time of 6:42pm and an additional entry: "*[a]t 1845 hours inmate returns from Gosford Hospital*". The document identified that the duty officer was Daniel Birch and the escort officers were Mr Slingsby and Mr Uerata.[166]

158. At 5:35pm, Bailey was triaged and 10 minutes later he was seen by the ED doctor, Dr Kathryn Porges. Dr Porges examined Bailey and she reported in her statement that Bailey was polite and a bit stressed. A chest x-ray was performed with normal results. Dr Porges explained that anxiety and stress can manifest in physical symptoms such as chest pain. Dr Porges did not consider that Bailey required a mental health assessment because, in her opinion, he was not in distress and that "*the triggers for a mental health assessment are suicidality or significant risk of self-harm*." Dr Porges considered the possibility that the chest pain may have been reported as a rationale for an excursion from goal but to her Bailey did not appear in distress.[167]

159. Mr Cargill recalled Bailey returning from hospital and it appears that Mr Cargill was of the view that Bailey was not genuine about having had chest pain because he had asked Mr Cargill if there was any medication rather than making a complaint about the pain he was in. Mr Cargill said that he had looked at the discharge summary and remarked to Bailey that Bailey was fitter than he was.[168] I do not think that the exchange between Mr Cargill and Bailey was sufficient for Mr Cargill to form the opinion that Bailey did not genuinely suffer from chest pain and that he was feigning it; however, it is highly possible he was correct given Dr Porges' findings and Bailey's earlier conversation with John Brown about his intention to fake an illness so that he would be taken to hospital. That is not to say Bailey was not feeling those pains earlier during the day when he was reportedly having a panic attack.

160. Although there is no transcript of the CIC prior to Bailey attending hospital, there is a transcript of a 7:20pm CIC after Bailey returned from the Hospital.[169] In his evidence, Mr Cargill said he was not sure whether it was his voice; however,I am of the view he did answer the call. The transcript provides that:

> *"B: yeah chief can you come and turn this TV off for us please?*
> *CO: mate did you get dinner tonight?*
> *B: ah I didn't eat it though, if you've got a spare one can I please have it?*
> *CO: but you got dinner didn't you.*
> *B: yeah.*

[166] Ex 1, Vol 4, Tab 46.5,
[167] Tab 25, Statement of Dr Porges, pp. 9 - 10.
[168] Transcript 6/5/21 T6.9-17
[169] See Ex 10.

CO: Can you guess whose turn it is now mate?
B: what?
CO: can you guess whose turn it is now?
B: for what?
CO: for dinner.
B: whose?
CO: yeah mine.
B: Oh right…
CO: You know what chance you've got of getting that TV adjusted don't ya?
B: yeah.
CO: good."[170]

161. Mr Cargill has said that he did not consider this conversation inappropriate, and that it is dependent on the context. Bailey did not make any further CICs and appeared to sleep throughout the night.

162. Dr Eagle agreed with Ms Mahony's proposition that Bailey was likely having a panic attack between 12:05pm and 1:05pm on 4 November 2019. Dr Eagle also agreed that the intervention of placing Bailey with John Brown appeared to resolve those issues.[171] Dr Furst thought that the intervention was in a positive way extraordinary (in a prison context).[172] Professor Large also agreed that having someone with Bailey was an appropriate response. He gave this evidence:

> "*Most people having a first panic attack actually end up in an emergency department. They think they're having a heart attack or an asthma attack, or they think something catastrophic is happening. Some patients will go to the ED a few times and a small number will go lots of times. But most people will be, you know, told that it's an episode of panic and won't run the gauntlet of an emergency department too many times. There are a whole lot of different treatments for panic. Being with somebody else is a - most people who have panic attacks have them when they're on their own. So even people who have panic disorder with agoraphobia usually are quite capable of moving around if they're with someone else. So being with somebody else is a very important way that people with panic disorder regulate that; and I suppose these days, in these times, it would be calling someone. I think Lifeline get a lot of calls from people who are panicking*."[173]

163. Dr Eagle opined that Bailey was likely exhausted from the anxiety and panic attacks he had been experiencing since being placed in the cell. She described the symptoms of a panic attack thus:

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[170] Ex 10, 19:20:02, Item #24 – File name: Call 1920.
[171] Transcript 20/10/21 T304.5-10.
[172] Transcript 20/10/21 T302.25.
[173] Transcript 20/10/21 T304.46-305.10.

> *"…the person experiences sort of a heightened sense of panic or heightened fear, to use a layman's term, and that's associated with physical symptoms, so sometimes they feel like they can't breathe, they feel like they might have chest pain, they feel overwhelmed, they feel like they're going to die, and it's an irrational feeling and it makes the person feel like the sensation is never going to end, and that would be considered a characteristic panic attack, and a panic disorder often comes on - panic attacks then come on because of the person's fear that they're going to actually have another panic attack, which then triggers further panic attacks and it becomes a self-perpetuating disorder…*".[174]

Escort personnel and documentation on 4 November 2019

164. Mr Cargill did not refer in his statement to having completed the escort documents for the correctional officers to take Bailey to hospital on 4 November 2019. That they were the same officers on 5 November 2019 seemed to have escaped his memory or attention. Those officers also say they have little to no memory of the transport escort on 4 November 2019.

165. During his evidence, Mr Cargill was taken to CCTV clips of the escorts and of Bailey arriving and departing the Hospital via the ambulance bay. When he arrived, Bailey stepped out of the ambulance and Mr Slingsby held him at the handcuffs and walked with him into the ED. When they departed, Mr Slingsby did not hold onto Bailey at any time. Mr Uerata was armed and he followed them on each occasion at a distance. The CSNSW van was parked rear to kerb in a parking bay at the far end of the ramp on 4 November 2019 and also took that position on 5 November 2019. Gosford Hospital had sent Kariong CC an email indicating where the prison vehicles should park. It appears that CSNSW did not conduct any intelligence relating to the location, however they should have given that it was a recently completed construction.

166. After watching the footage, Mr Cargill was asked whether (when he prepared the escort documents) he had the expectation that the unarmed officer would have a physical hold of Bailey whilst returning to the van. Mr Cargill said, "*[i]t was usual. I don't know whether – I can't think back to whether I had an expectation at the time, but it, it was – it was usual to me".* The question was again put by counsel assisting and Mr Cargill said, *"I think the footage does not meet my expectation*".[175]

167. The "Transfer to Hospital or other place specified order" is a two page document authorising inmate movements pursuant to s. 24 of the *Crimes (Administration of*

[174] Transcript 20/10/21 T289.42- 290.1.
[175] Transcript 5/5/21 T98.30-41.

Sentences) Act 1999. On the first page it has sections 1-7: 1 Inmate Details, 2 Order, 3 Period of Absence, 4 Location of escort, 5 During escort, 6 On discharge and 7 Approval. The second page has sections 8 Additional/special considerations and 9 Assurance. Accompanying the s. 24 order is a single page document entitled "Escort-assessment" which has three sections: 1 Inmate details, 2 Assessment and 3 Summary (which includes an authorisation). A third document is a page which has the photograph of the inmate, their identification and date of birth.

168. The s. 24 order for 4 November 2019 indicates in section 1 that Bailey had no escape history, there were alerts and there was an OIMS printout. Section 8 mandated that Bailey remain in company of the correctional officer at all times, be treated as high risk at all times, be handcuffed and ankle-cuffed (the latter only to be removed after approval) and that one officer must be armed. Under "*[o]ther*", there is in handwritten words: "*Close monitoring – has suicidal ideation*". Section 9 indicated that all reports and documents were attached as per policy and procedure, and that there had been no contact with security at the local unit, local police command or the Hospital security.

169. The escort assessment for 4 November 2019 at section 1 identified that Bailey was an unsentenced Classification B inmate on protection and that there were alerts. In section 2, it identified that Bailey did not have an "E" classification or escape record on OIMS and there was no known intelligence that may impact on the escort. In section 2 under "[o]ther", it is indicated by a tick of the respective "yes" boxes that there are issues and that there is information recorded in case notes that may impact on the escort. The section 3 summary has this recorded: "*Psychologist says that Mackander has "suicidal ideation". Officers are reminded that he is to be handcuffed and ankle cuffed at all times and closely supervised*".[176]

170. Mr Cargill explained that the purpose of the escort assessment was to provide information to the escort officers as to the risk and how to manage risk.[177] He said that he creates the assessment from "*information that's available at the time. So I look at OIMS, I look at his case file if that's available, I talk to people and whatever information that's just available"*.[178] He could not recall much of the afternoon of 4 November 2019, other than that it was extremely busy. He said that he did mention to the escort officers that Bailey was impulsive and so they were to watch him closely.[179]

[176] Ex 1, Vol 4, Tab 46.25.
[177] Transcript 5/5/21 T94.19-24.
[178] Transcript 5/5/21 T94.44-47.
[179] Transcript 5/5/21 T95.10.

171. Mr Cargill, having viewed the CCTV footage of 4 November 2019, said that although the officers were in close proximity to Bailey, it was not in the usual way as the armed officer is usually further away [redacted] Mr Cargill was asked whether the usual way included an escort officer having hold of an inmate and he replied that "*[i]t's customary...a lot of officers will hold the handcuffs, hold onto a restraining belt on an inmate or grab a hold of the inmate…that's pretty customary*".[180] He was asked what he considered to constitute "*close supervision*" of an inmate and he said it is "*that they're aware of the risks, that you're alert, that you are close to the inmate*".[181]

172. Mr Cargill said that the CSNSW Operating Policy and Procedures[182] ("COPP") [redacted] and he believed that (if he had been the escort officer) he would have had hold of Bailey.[183]

173. On 4 November 2019, Mr Uerata opened the van door rather than Mr Slingsby, and in this regard Mr Cargill said:

> "[redacted]*"*[184]

174. Mr Cargill had also earlier said:

> "*I mean officers will do, will do things in, in different ways.* [redacted]
>
> [redacted]*"*[185]

[180] Transcript 5/5/21 T97.30.
[181] Transcript 5/5/21 T97.35.
[182] Ex 1, Vol 5, Tab 64, COPP 19.6 Medical Escorts – unscheduled medical escorts; and also, Ex 12, Tab 18, COPP 19.6 General Escort Procedures 1.1 (dated 12 March 2020).
[183] Transcript 5/5/21 T98.1-6.
[184] Transcript 6/5/21 T15.7-15.10.
[185] Transcript 5/5/21 T98.21-30.

175. The relevant policy is 19.6 COPP (Medical Escorts) [186] which must be read in conjunction with 19.1 (General Escort Procedures).[187]

176. COPP 19.1[188] states at 1.1:[189]

> "*Escorting officers are responsible for the safe and secure transport of inmates. It is the responsibility of the officer approving an escort to ensure that sufficient correctional officers are assigned to the escort to maintain the security, control and supervision of the inmates on escort*."

177. COPP 19.6 (Versions 7[190] and 9[191]) state:

> "*1.1 Authority and responsibility for medical escorts*
>
> *"…The primary responsibility of the escorting officers is to provide adequate security and supervision appropriate to the level of identified risk regarding the inmate*
>
> *…*
>
> *4.1* [redacted]
>
> *…*
>
> *5.5 procedures during and after the medical escort*
>
> *… Remain vigilant at all times* [redacted]

178. Shortly after Bailey's death, Kariong CC introduced a Local Operating Procedure ("LOP") for medical escorts that requires [redacted] during any inmate movements. At 5.17, the policy describes such technique:

> [redacted]

[186] Ex 1, Vol 5, Tab 64, Version 1.7; Ex 12, Tab 18 (Version 1.9).
[187] Ex 1, Vol 5, Tab 64, Version 1.7 p. 2; Ex 12 Tab 18 Version 1.9, p. 2.
[188] Ex 27.
[189] Ex 27, p. 6.
[190] Ex 1, Vol 5, Tab 64, pp. 5, 13-14, 18-20.
[191] Ex 12, Tab 18, pp. 5, 13, 17-18.

[redacted]*"*[192]

179. At 5.18 the LOP states:

> "*At the completion of the medical appointment escorting officers are to return the inmate to the escort vehicle* [redacted]
>
> *Once the inmate has been secured in the escort vehicle escorting officers are to contact KCC and inform them that the appointment has been completed and the escort is returning to the centre*."

180. Mr Cargill is not correct to say that the LOP requires [redacted], as the policy makes no reference to this at all. Mr Dolling, who wrote the LOP, was unable to identify from any CSNSW policies where he obtained the term [redacted] other than it being a term he learned when he worked in the High Risk Escort section.

5 November 2019

181. Though Bailey had been told on 4 November 2019 that the RIT would be reviewed at 8am, Bailey was not taken to the meeting until after 11am. Bailey woke at 7:28am and made his first CIC at 7:35am, asking what time the psychologist was coming to speak with him. He was told probably in a half an hour to an hour. [193] At 7:40am, two officers attended the cell and spoke to Bailey. It is unclear who they were and what they said.[194]

182. Bailey waited until 8:13am until he again pressed the CIC a couple of times with no response. He pressed the CIC again at 8:15am and asked, "*how much longer, please it's distressing me out*".[195] The officer told him he was coming down to see him in a minute. At 8:22am, Bailey asked "*what is happening…can you come and get me out of the cell please. Or … speak to the psych or the nurse*". Despite the fact that RN Georgiou had commenced work that day by 7:30am, the officer told Bailey that the nurse was not in yet and that she would come and see him.[196] At 8:24am, Bailey asked

[192] Ex 12, Tab 13, LOP 18/61.
[193] Ex 11, Item 1.
[194] Ex 22 is the source of times of CICs, cell attendances and departures and I have rounded the times. I note that the timestamp on the CCTV footage is 71 seconds ahead of the CIC timestamp.
[195] Ex 11, Item 2-4.
[196] Transcript 7/5/21 T10.2.

when he was able to get out of the cell. He was told to calm down and stop using the CIC.[197]

183. Officers delivered Bailey breakfast at approximately 8:30am. An hour later at 9:25am, Bailey made a CIC again, asking if the nurse had arrived and how long she would be.[198] Bailey was told she would come when she was ready and he had to just sit down and be quiet for a little bit. At 9:33am, Bailey used the CIC and complained of chest pains and asked when the nurse was coming. The officer replied he would let the nurse know.[199]

184. At 9:42am, officers attended the cell and took Bailey to be reviewed by RN Georgiou.[200] RN Georgiou's notes record a time of 8:50am; however, this seems to be an error and should have recorded 9:50am.

185. RN Georgiou's notes record the following:[201]

> "*Nursing: Pt was brought to clinic by CSNSW c/o chest pain – also advised pt was sent to Gosford Hospital last evening c/o chest pain – O/E D/C summary-? musculoskeletal – cardiac cleared and sent back to centre. CSNSW did not advise AHNM [After Hours Nurse Manager] – spoke [author] with FM and requested Senior to call AHNM in future. Pt then stated he was fine but wanted out of the RIT cell. Obs BTF [Between the flags]. Pt advised I was unable to take him off his RIT, but we would convene with team as soon as possible to discuss and review – Pt very agitated and was removed by numerous CSNSW officers;[202] to convene RIT asap*."

186. RN Georgiou explained that procedures had not been properly followed when Bailey had been taken to the Hospital the previous evening. She said that after 4pm, when there was no Justice Health staff on the premises, the procedure required Mr Cargill to call the after hours nurse so that any health information could have been sent with Bailey to the Hospital.

187. Bailey was returned to the observation cell at 9:57am. Within a minute of being back in the cell Bailey made a CIC asking if John Brown could come to his cell.[203] Mr Lloyd

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[197] Ex 11, Item 5-6.
[198] Ex 11, Item 7.
[199] Ex 11, Item 8.
[200] Ex 22.
[201] Ex 1, Vol 7, Tab 99, [30].
[202] In her evidence RN Georgiou clarified that they did not take hold of Bailey but their presence encouraged him to go [back to the cell]: Transcript 7/5/21 T17.10-25.
[203] Ex 11, Item 9.

was the officer who spoke with Bailey. He told Bailey that John Brown had already been spoken to and he was not coming up at the moment as he was exercising.[204]

188. John Brown gave evidence as to why he did not visit Bailey in the cell on 5 November 2019. In his notes, he said that he had seen Bailey being taken to the clinic and that Bailey seemed distressed. Bailey caught John Brown's eye and asked him to come up and see him. John Brown had a discussion with CO Danny Field and asked him what he thought and according to John Brown, CO Field suggested that Bailey was acting and expecting to be treated like a juvenile offender. John Brown said that he agreed with that assessment and decided not to visit Bailey so that Bailey would learn to cope on his own. He said, "*shortly afterwards, more senior officers made the decision that I was not to go up and see him*".[205]

189. Bailey made two CICs at around 10am, which were answered. Bailey said, "*you've got to get me out of here, this is fucking making me sick. It is stressing me out, pleas*e". He was told he would be spoken to a bit later and that he had to settle down and if he did not chill out he would be in there for longer. Bailey was told to settle so that things would go his way. A minute later in the next CIC, Bailey complained of bad chest pains and asked to see the nurse. He was told that the nurse had just seen him, there was nothing wrong with him and that it was his attitude. Bailey then said he had been vomiting so how could the nurse say that he was okay. He was told to stop using the CIC.[206]

190. Ten minutes later at 10:11am, Bailey made another CIC complaining of severe chest pains and asked for someone to come and see him. The officer said he would come down and speak with Bailey, which he did, talking to Bailey through the door for a couple of minutes.[207]

191. Ten minutes later at 10:32am, Bailey made another CIC complaining that, "*I've got vomit everywhere can you get the fucking nurse for me?*" Mr Lloyd said no. Bailey replied that the cell was full of vomit and Mr Lloyd told him if he was going to vomit, it would be better to do so in the toilet. Mr Lloyd then said, "*[i]nstead of making a mess of your cell where you're probably going to be living for probably a while now with the way*

[204] Transcript 19/10/21 T109.30-44.
[205] Ex 1, Vol 6, Tab 76, p 12.
[206] Ex 11, Items 10 and 11 - Officer Lloyd.
[207] Ex 11, Item 12 – Officer Lloyd.

you are carrying on, I suggest you either spew in the toilet and clean up the mess there now."[208]

192. Bailey made another call at 11am, however that does not appear to have been answered. However, an officer attended the cell and took Bailey out of it at 11:04am to attend the meeting with the RIT review team.

193. There has been an issue in the inquest as to how long the RIT team met to consider the review. It would appear that, at least in regards to Bailey's participation, he was likely in the meeting for 15 minutes and that the team had made their decision within about 15 minutes of his departure from the meeting.

194. After Bailey left the meeting, rather than being returned to Cell 41, he was taken to his accommodation unit which he shared with John Brown. CCTV footage showed Bailey entered the unit at about 11:30am. John Brown said in his statement that when he asked Bailey how he was, Bailey told him that he was terrified that they would send him back to the observation cell. John Brown assured him that if they did take him back it would only be for one night and he had already managed one night so another night would be fine. Bailey went to the common room and began pacing, which was not unusual for him. John Brown thought that Bailey's "*demeanour and mood did not seem to be out of the ordinary with the exception of maybe slightly heightened anxiety due to the fear of being sent back to the obs cell*".[209] Bailey went into their cell for a couple of minutes alone and returned to the kitchen with bread and margarine and made toast. Shortly after this, Ms Dolling came to the accommodation unit and escorted Bailey out of the accommodation unit.

195. RN Georgiou said Bailey was returned to the meeting room after Mr Dolling left and although she could not say who spoke to him, he was told what decision was made in the meeting. She said he was "*definitely not impressed…I don't know whether he knew it going to happen...but…it wasn't as emotive as it…had been that morning in the clinic*".[210] In contrast, RN Georgiou's notes written that day recorded that he was very agitated and distressed at having to return to the assessment cell.[211] She said she told Bailey that she would make contact with the mental health nurse and that he would be seen the next day.[212] She said that the review by the mental health nurse would involve

[208] Ex 11, Item 13 – Officer Lloyd.
[209] Ex 1, Vol 6, Tab 76, p. 13.
[210] Transcript 7/5/21 T26.16-25.
[211] Ex 1, Vol 3, Tab 43, p. 62.
[212] Transcript 7/5/21 T27.15.

a mental health assessment as she was not qualified to carry out such an assessment.[213]

The Risk Intervention Team review

196. The policy relating to RIT review is contained in sections 5 to 8 of CSNSW COPP 3.7, "Management of Inmates at risk of self-harm or suicide".[214]

197. The policy requires each team to have a co-ordinator who must be a custodial officer of SCO rank or above, a Justice Health member and an Offender Services and Programs staff member (SAPO). The non-Justice Health members must have completed the **Awareness of Managing At Risk Offenders** (which is an online-e-learning module) and the co-ordinator must additionally have completed the two day training course called **Managing At-Risk Offenders** (which is a program requiring personal attendance at the Brush Farm Corrective Services Academy). [215]

198. The task for the RIT review team is to assess the inmate's risk of harm or suicide with reference to the **RIT Assessment Interview and Guidelines,[216]** although such a document does not seem to have been used by the team on 5 November 2019. Ms Dolling, who had participated in at least 50 RIT reviews, said that the team does not in fact carry out an actual risk assessment. She said:

> "*I would feel that is part of the - like, they have - they don't do the actual risk assessment, like, the inmate under threat assessment, no. But it's part - what you would conduct, under the powers of least restrictive care, you have to assess what threats the inmate has made, as to what they can have access to, or what diversionary practices are beneficial for that particular inmate. So a threat assessment is carried out as part of the package, per se*."[217]

199. There can only be two outcomes of a review:[218]

    (i) If the inmate is not considered by the team to be at risk and does not require additional management strategies, the team proceeds to Part 4 and completes a **discharge plan**.

[213] Transcript 7/5/21 T27.33.
[214] Ex 1, Vol 5, Tab 63.
[215] Ex 1, Vol 5, Tab 63, p. 19 of 34.
[216] Ex 12, Tab 17.
[217] Transcript 19/10/21 T128.45-50.
[218] Ex 1, Vol 5, tab 63, p. 20 of 34.

(ii) If the inmate is considered to be at risk, then the team is required to develop a **Management Plan** which should include strategies that directly **target risk factors** while maintaining **principles of least restrictive care**.

200. The Management Plan must be **based on all available information.** The duration of the Management Plan can be short or long - such duration as determined by the strategies required to manage the inmate's risk of suicide or self-harm. [219]

201. The policy has a hyperlink for the co-ordinator (or the other CSNSW members) to access numerous forms and annexures including: Inmate discipline checklist, Inmate interview questions to further evaluate risk, Inmate undertaking to share accommodation, ISP/RIT management plan observation record form, ISP/RIT management plan reference guide, Risk factors for consideration: reference guide, RIT assessment Interview and documentation guidelines and Suicide and self-harm procedure checklist.[220]

202. The '**Suicide and self-harm: ISP/RIT management plan-reference guide**' is fairly limited in that it provides a general definition of what is considered to be minimum, medium and maximum restrictive options. Though it refers to diversionary activities, it does not refer to human interaction which is a field in the RIT Management Plan. It does not refer to access to a person other than staff, nor does it refer to telephone calls under any of the options for diversionary activities.[221]

203. The RIT review process was somewhat defective from its inception as the co-ordinator Mr Lloyd had not attended the two day training **Managing At-Risk Offenders** which was a mandated pre-requisite to be a co-ordinator of a review team. Not only had he not completed the training, he was not aware of any of the policy applicable to a review and although he knew the policy existed he did not attempt to access it. Further, he incorrectly considered that his role on the RIT was nothing other than to provide advice about security issues.

204. That he was the co-ordinator on that day seems to be a default task which fell upon the senior compound officer (whoever it was who was rostered). The inquest learned that on 5 November 2019 at Kariong CC, Ms Dolling was on duty. She had not only undergone the mandated training to be a co-ordinator, but she had significant

[219] Ex 1, Vol 5, tab 63, p. 20 of 34.
[220] Ex 1, Vol 5, tab 63, p. 30 of 34.
[221] Ex 12, Tab 15.

experience in convening RIT reviews. She should have been tasked with co-ordinating the RIT review for Bailey. The fact that Mr Lloyd had no interest in looking at the policy, in regard to not only his role but what was required to be considered in carrying out the task, fell well below the standard required of his position that day.

205. The second reason that the RIT review process was defective is that the team had access to limited and inadequate information because there were no OIMS or records of observations or incidents of Bailey, his distress and means to alleviate it whilst in the cell on 4 November 2019. There was no reference to the numerous CICs, Bailey's distress, vomiting, panic attacks and anxiety arising from his confinement in the assessment cell. There was no record that he had been told what he needed to demonstrate to be discharged from the cell (namely, be settled and calm – which he apparently did from 7:30pm on 4 November 2019 until at least after 8am on 5 November 2019, when it became apparent to him that the review had not occurred at time he had been told it would).

206. Ms Thompson and RN Georgiou were aware of Ms Hyde's OIMS setting out why she raised the Mandatory Notification and they all had Ms Grimshaw's ISP and Mr Cargill's OIMS report of Bailey attending hospital on 4 November 2019 for chest pains. In addition, RN Georgiou had discussed Bailey with Ms Hyde (when Ms Hyde was considering raising the Mandatory Notification), she had met Bailey briefly when she dispensed his medication and she had reviewed him that morning in the clinic before witnessing his agitation (when he was informed, contrary to his expectations, that he had to return to the observation cell). It was not until RN Georgiou was preparing for the inquest a couple of weeks prior to giving her evidence that she learned of Bailey's use of the CIC and the course of events on 4 November 2019. She confirmed in her evidence that these were not known and not discussed in the RIT review meeting.[222] Accordingly, the RIT review team really had no understanding of what was happening for Bailey.

207. It is unclear what Mr Lloyd brought to the RIT meeting, he had had dealings with Bailey before the RIT review meeting - over the CIC about whether Bailey could have contact with John Brown. Mr Lloyd said in his evidence that he tried to contact John Brown to ask "*him to come up and talk to Bailey, I believe my response is one of those knocks ups there where he said no, he's already spoken to him*".[223] John Brown's recollection of why he did not see Bailey that day casts a different light on how that came about

[222] Transcript 7/5/21 T8.5-24.
[223] Transcript 19/10/21 T113.10-15.

and indicated that the senior correctional officers determined that he was not to visit Bailey. I prefer John Brown's version and it is consistent with the Part 3 Management Plan.

208. It appears that the review meeting did not have access to or use the document **RIT Assessment Interview and Guidelines**. The documentation relied upon by the team is not apparent as no reference is made to it in the records of the review, and it is not attached to the Management Plan. The lack of documentation (including with respect to what was asked and said in the meeting, how Bailey presented, what decision was made and why) makes it difficult to scrutinise the RIT review decision-making process.

209. The RIT review process was derailed when the Functional Manager, Mr Dolling took it upon himself to be involved in the review decision without any regard to the fact that he too (like Mr Lloyd) was unaware of the policy relating to RIT management. Further, his belief was that in Kariong CC, if an inmate is on a RIT they are in an assessment cell with no regard to least restrictive options.

210. Mr Dolling gave evidence that he did not involve himself in the meeting and that he did not even enter the room.[224] The evidence of the witnesses who comprised the review team contradict him completely. Mr Dolling involved himself in the RIT decision when he had no standing, and worse he had no training and clearly no regard to the process involved to safeguard Bailey's wellbeing and safety. As Counsel Assisting submitted, the information that the RIT team used to make their decision needed to have been accurate and informed by policy. In my views, Mr Dolling's participation effectively disrupted and vetoed the RIT decision-making, and his participation was not documented which, as Counsel Assisting submitted, it should have been. His involvement interfered with the review process so significantly, that taken together with Mr Lloyd's inexperience and indeed lack of standing to be the co-ordinator, I do not consider that the review process was appropriately or adequately conducted. Counsel Assisting submitted that the RIT review team took into account the incorrect assessment by Officer Dolling of the options available. She submitted that it was open to the team to consider and implement a plan whereby Bailey remained in the assessment cell overnight and has some time in the yard or with his cell mate outside during the day. A tailored placement option could be made available at Kariong CC. As Counsel Assisting said, Ms Dolling was an impressive witness who demonstrated that she was familiar with both process and policy. I accept those submissions.

[224] Transcript 18/10/21 T13.

211. The RIT review documentation does not require times to be recorded. Where the length of the meeting is put forward to indicate the time taken by the team to make its decision, the document should have such a timestamp to record the time commenced and ended. Dr Furst, in his evidence opined that the length of time of the meeting, which he understood was about an hour indicated that the team spent a lot of time considering a difficult decision about what to do with Bailey. Length of time may be some measure but it may be that a better measure is to assess the training and information brought to the decision.

212. Ms Thompson had engaged in the two day training course in September 2019.[225] She had very little experience participating in a RIT team, having participated in "*one or two*" prior to 5 November 2019.[226] She said, "*I've done about five RITs in the whole time I have been a SAPO. And probably three of them was prior to training and one - one was after training at Kariong"* and that was just a few weeks before Bailey's RIT review. [227] Mr Lloyd had no RIT experience and said that the people responsible for making the assessment of Bailey's mental health were Ms Thompson and RN Georgiou.[228] Though RN Georgiou was not a mental health nurse, as a registered nurse of 15 years she was qualified to make that decision.

213. There appears to be no document which the team is required to complete indicating that it had made a finding that Bailey was still presenting as a risk of suicide. It might be assumed that, because the team completed a Management Plan rather than a Discharge Summary, a decision had been made that Bailey was at risk of self-harm. The policy provides guidance for a review of RIT management plan which lists a number of matters that the team should consider to re-assess the inmates ongoing risk of suicide[229].

214. Ms Thompson made an OIMS case note after the meeting and recorded that:[230]

> "*The inmate was placed on RIT yesterday 04/11/2019 by the psychologist. RIT review today was attended by JH nurse L Georgiou A/SCO R. Lloyd and SAPO Thompson. The inmate presented as happy and stated that he had no intentions of hurting himself or committing suicide. The inmate was questioned as to why he would tell the psychologist yesterday that he had daily thoughts of suicide. The inmate*

[225] Transcript 18/10/21 T71.32.
[226] Transcript 18/10/21 T71.15-17.
[227] Transcript 18/10/21 T44.22; T71.20-22.
[228] Transcript 18/10/21 T80.46.
[229] Ex 1, Vol 5, Tab 63.
[230] Ex 1, Vol 4, Tab 46.17, p. 19.

stated that he was having a bad day yesterday. He stated that he had spoken to his friend over the phone and had become upset with the phone call. The inmate did not say what was said in the phone call, only that it upset him. The inmate asked not to be put back in the safe cell and stated that last night being housed in the safe cell was the worst night of his life. Again he reiterated that he was fine and that he was not going to hurt himself. The inmate was taken from the room and a decision was made that he should stay in the safe cell and will be reviewed again tomorrow."

215. Ms Thompson's OIMS case note does not say that there had been a determination that Bailey was considered at risk of suicide or include the reasons that informed that decision. The final sentence suggests that the decision that was made was a conflation of risk and management. However, it was not the decision that the policy required.

216. RN Georgiou made some short notes after the meeting:

"*5/11/19 – 11.00*

Nursing: RIT with Senior CSNSW and SAPO Marian – lengthy meeting (over) > 1 hour to discuss, FM also in attendance –due to pts inability to detail why he said he would have suicidal thoughts and unable to clearly outline why he wouldn't team not confident in terminating. Author to email MHN (Mental Health Nurse) to organise a review as soon as possible. Pt able to have reading material and greens [clothes] in cell. Pt very distressed about decision."[231]

217. The result "*team not confident in terminating*" does not indicate that the team considered that Bailey was at risk. Rather, at best it is indicative of the team being unable to make a decision on the material that they had. There is no mention in the Part 3 RIT review documents or Ms Thompson's OIMS that Mr Dolling was present, let alone what impact that had on the meeting.

218. In her evidence, Ms Thompson said that Ms Hyde had told her on 4 November 2019 about what Bailey had said in the interview with Ms Hyde. Ms Thompson said that on 5 November 2019, she was of a mind to keep Bailey on the RIT because at the forefront of her mind was "*the thought he'd put into the impact it would have on his family, if he had - if he did commit suicide*."[232]

219. RN Georgiou gave evidence over a full day. She was a co-operative witness who attempted to assist the inquest and she gave her answers in a considered manner. In

[231] Ex 1, Vol 3, Tab 43, p. 62 (transcribed in statement dated 23 April 2021 of Lara Georgiou at Ex 1, Vol 7, Tab 99, p. 21, [30]).
[232] Transcript 18/10/21 T46.10.

relation to her assessment of the risk that Bailey presented on 5 November 2019, she (like the other RIT review members) did not make any notes. However, in her statement RN Georgiou referred to a list of risk factors. She said in her evidence that she identified those risk factors from "*a combination of the information I'd been given the day before with the psychologist, looking at his file, communicating with Bailey, watching like Bailey's presentation as a ...collaborative assessment*". She agreed in her evidence that when she was making her statement she referred to Justice Health policy "Clinical care of people who may be suicidal".[233]

220. RN Georgiou said in her statement that she was aware of the Justice Health policy entitled "Clinical care of people who may be suicidal" and referred to a list included in section 3.1.2, "Comprehensive Assessment". In her statement, RN Georgiou itemised features of Bailey's history and presentation at the time of the RIT that gave rise to an increased risk of suicide. Though the list in section 3.1.2 might apply to most remand inmates at probably any given time, further examination established that at the time the indicia were not really considered by RN Georgiou (but rather she did so at the time she was preparing her statement).

221. The policy clearly says that "*[t]he evaluation should include a thorough assessment of the patient's presentation, history … and current mental state. An important element of suicide and DSH risk assessment is the identification of risk and protective factors associated with DSH and suicide"*.[234] I am not persuaded that RN Georgiou engaged in such an assessment within or outside of the RIT review meeting. The RIT review meeting certainly did not.

222. Ms Thompson said that the team discussed "*maybe stepping [Bailey] down*".[235] She said, *"[i]t was to sort of keep him in the cell of the wing at night time so he could be observed to letting him to [sic] the yard in the day."*[236]. This would mean that whilst Bailey would remain on the RIT, it would be on a revised placement. She said there was a discussion about buddying Bailey up in the cell with John Brown but the team never got that far.[237] She said that Mr Dolling came into the room and interrupted the discussion, that Mr Lloyd left taking Bailey with him and then Mr Lloyd returned. In

[233] Ex 1 Vol 5 Tab 57 Transcript 7/5/2021 T 28.30-50.
[234] Ex 1, Vol 5, Tab 57, p. 5 of 13.
[235] Transcript 18/10/21 T46.45.
[236] Transcript 18/10/21 T47.12-13.
[237] Transcript 18/10/21 T47.20-30.

relation to the role Mr Dolling took, Ms Thompson said "*I think because he was acting manager of security that he was able to convince the RIT review*".[238]

223. Ms Thompson said of Mr Dolling, "*He just sort of said, "How's things, how's it going" and that and because Bailey was there we didn't really want to discuss it… so Rick took Bailey out of the room and that's when Rick left the room. And we were just talking and we were just basically discussing what was best for Bailey; and that's when, you know, Terry said: "Keep him on the RIT*."[239]

224. Ms Thompson said that though she had not been aware that Bailey had used the CIC on 4 November 2019,[240] she was of an opinion Bailey was not in a good place[241] (mentally). It is apparent that she did not have much understanding of what that place was or seek elaboration. Ms Thompson clearly took her task of being on the RIT review seriously and she and RN Georgiou at least took time to discuss some options, and the meeting apparently took longer than most such meetings. However, the length or duration of the meeting does not indicate much other than that a decision was difficult to reach. Perhaps co-ordination of the meeting with reference to the policy and guidelines would have assisted the members in carrying out a task that they probably were not particularly equipped to carry out.

225. The two page form which follows the ISP is called the 'Part 3 Risk Intervention Team Management Plan'. The Management Plan's first section is a question, "**What is the current presentation and situation of the inmate?"** which requires an answer and allows for an entry over only three lines. This section in the form for Bailey was left completely blank. The Management Plan requires reference to the **"Suicide and self-harm: ISP/RIT management plan – reference guide",** which presumably would assist the team to consider the appropriate matters to answer that question. If that question is directed at whether the RIT review team has determined that the inmate is at risk of suicide, it should ask that question and provide for substantially more matters to be documented.

226. Though the next part of the form relating to **Cell Placement, Observations and Diversionary Activities** (similar to those sections in the ISP) reminds the team that the cell placement should be the **least restrictive relative to risk**, there is no provision for the team to record why that decision was made. The **Diversionary**

[238] Transcript 18/10/21 T47.42-43.
[239] Transcript 18/10/21 T48.1-5.
[240] Transcript 18/10/21 T43.10-13.
[241] Transcript 18/10/21 T48.25-31.

activities/human interaction section on the form for Bailey only included two of the three activities from the previous day's ISP, and there is no recorded explanation as to why Bailey was no longer to have contact with a mentor such as a John Brown.

227. It would seem that the conditions of Bailey's cell placement were more restrictive under the Management Plan than the previous day's ISP. Though the Management Plan stated that Bailey could have telephones calls, it appears that this did not occur. This strongly suggests, especially without a documented explanation, that narrowing his diversionary activities (particularly the withdrawal of human interaction) was a "stepping up" rather than a "stepping down" of restrictive measures.

228. Having heard from the witnesses Mr Lloyd, Mr Dolling, Ms Thompson and RN Georgiou, I am of the view that Mr Dolling, despite his evidence to the contrary did participate in the RIT review meeting. This resulted in an outcome contrary to Ms Thompson's intent to commence "*stepping"* Bailey *"down*", this was stepping up the deprivations without any apparent basis for it.

229. It was not possible to ascertain from Mr Dolling the reasons as to why there was a narrowing of Bailey's diversionary activities because he denied having anything to do with the meeting. In the assessment cell, there was 24/7 lighting, no access to any recreational environment and no access to anyone who cared for Bailey (such as in person with his cell-mate). I note under 6.2 of the Policy it says:

> "*The RIT aims to settle the emotional state of the inmate and address any non-coping behaviours. This may require assistance from staff outside the RIT. It there sets out a number of referrals including Justice health, a CSNSW SAPO or a CSNSW psychologist*."

230. Bailey's form had a referral to a Justice Health Mental Health nurse, but other than that the management plan seemed not to direct its attention to setting Bailey.

231. I do not for a minute suggest that Ms Thompson or RN Georgiou did not have care and concern for Bailey, they clearly did, but it seems that they were overridden by senior correctional officers.

232. In regard to the RIT review decision, Mr Dolling's interference in the RIT review process meant that the least restrictive options were taken away from the team. I do not think that RN Georgiou or Ms Thompson would otherwise have decided that Bailey be placed in the observation cell, other than perhaps during the night. Mr Dolling had

no regard to policy or any understanding of the concept of least restrictive care. Having said that, I do note that per the 5 November 2019 handover sheet which Ms Dolling gave to Mr Cargill,[242] Kariong CC had only one yard available to inmates as the tennis court (which included a basketball court) was closed and the oval was closed due to trucks being parked on it. Whilst that might explain why Bailey could not access the exercise yard, it does not explain why he could not spend time with John Brown. There is no evidence as to why Bailey had no telephone calls on 5 November 2019.

233. I note that Ms Dolling said in her evidence that it was quite commonplace at Kariong CC in 2019 for a RIT review team to allow inmates on a RIT access to the yard during the day, telephones and exercise as that "*quite often is helpful in managing them*".[243]

234. There is little utility in my attempting to decide whether the RIT team should or should not have determined that Bailey remained at risk of suicide on 5 November 2019, particularly as it does not seem to be a task required for them to really undertake. I agree with Dr Eagle's appraisal:

> *"…I found the reasoning to be really troubling. I thought it really, it was impossible for Mr Mackander to resolve. I think there's already no evidence that links suicidal ideation with suicidal risk and so then he denied, he was asked to deny the suicidal ideation which he did. He was asked to provide an explanation for why he had suicidal thoughts the day before which he'd already denied. So you know, he said, but he did say he had a bad day and he may not have been capable of articulating what he'd said or why he'd said to the psychologist whatever he said the day before anyway. I just think there was, like there didn't seem to be anything you could have possibly said that day that would have got him out of that cell from my perspective. It was inherently non-evidence based assessment and decision."*[244]

235. During the inquest, RN Georgiou was taken to section 3.1.2 of the Justice Health policy "Clinical care of people who may be suicidal" and agreed that the policy should have been complied with but was not. The policy required her to carry out an assessment of a patient's risk of deliberate self-harm or suicide, upon performing a well-documented comprehensive evaluation of the complete clinical picture. RN Georgiou was asked when she did that and she replied, "*I would say it was, like, a collaborative approach. It was on the day before the information had been given, my review in his file, ... his presentation in the morning, the RIT review. It was all, it was all compiled. I didn't*

[242] Ex 7.
[243] Transcript 19/10/21 T132.10-15.
[244] Transcript 20/10/21 T282.2-14.

have any real decisions to make for Bailey until that RIT review and it was a team approach also".[245]

236. The team approach was extremely limited because, even though the team knew Bailey had been to hospital the previous evening, according to RN Georgiou there was no discussion about it or his attendance at the clinic that morning.[246] They did not know about CICs, Bailey's anxiety and panic attacks, his time with John Brown or his telephone call to his mother. There did not discuss it because there was no record made for them to have regard to. The RIT team were apparently not informed by other correctional officers or Bailey himself of these things apparently because questions were not asked of him.

237. There was inadequate understanding and planning in relation to the Management Plan. RN Georgiou was not aware the Bailey had no access to an outside area for exercise as she did not know that the assessment cell exercise yards were closed due to being unsafe.

238. RN Georgiou said only a Justice Health mental health nurse could do a mental health assessment and refer Bailey to a psychiatrist.[247] As Kariong CC did not have a mental health nurse, there were two options for Bailey to be assessed consistently with the policy – either for him to see a GP who could prescribe medication or, if he needed to see a psychiatrist, RN Georgiou could send an email to place Bailey on a waiting list for a mental health nurse via telehealth.[248]

239. RN Georgiou was taken to the last section of page 1 of the RIT Management Plan, which has a heading "**Referrals"**. There are three boxes - the first for "**JH&FMHN**" (with room to apparently specify the purpose of the referral), a box for "**OS&P**" and a box for "**Other**". However, RN Georgiou did not refer Bailey to a mental health nurse. The first box is ticked, which suggests that Bailey was referred to Justice Health. The last box was also ticked, and the handwritten words are "*Mental Health Nurse*". RN Georgiou said that was different to the referral by email to a mental health nurse to which she referred to in her evidence.[249] I note that the Part 3 Management Plan did

[245] Transcript 7/5/21 T30.15-37.
[246] Transcript 7/5/21 T76.
[247] Transcript 7/5/21 T30.40-31.10.
[248] Transcript 7/5/21 T31.10-50.
[249] Transcript 7/5/21 T32.29.

not have an accompanying Incident Report ("IRM") as required, nor did it have Bailey's signature as required.[250]

240. Though Bailey was to be referred to a Justice Health Mental Health nurse RN Georgiou did not make a referral. RN Georgiou referred in her evidence to emailing a mental health nurse with a very detailed handover.[251] An email has been provided to the inquest which RN Georgiou sent at 4:46pm on 5 November 2019 to the AHNM and another person from Justice Health. That email attached the HPNF and said "*I have just seen him for his supervised medication with nil further issues*".[252]

241. In addition, at 12:34am on 6 November 2019, RN Georgiou emailed two individuals from Justice Health. She said with respect to Bailey:[253]

> "*I spent the majority of Tuesday with one patient, Mackander #609005 he is a young pt that had a lengthy consult with Erin (Psychologist) on Monday and she placed him on a RIT. He has some challenging behaviours and I have written some extensive notes on him. I hope he doesn't escalate for you, he needs transfer to an appropriate centre. I did not have the chance to complete the transfer out request or email Min about the appointment, could you please follow up today*".

242. RN Georgiou said in her evidence that had there been a second nurse at Kariong CC with a mental health background (though not employed as a mental health nurse) who could have performed a more detailed mental health assessment for Bailey. RN Georgiou agreed in her evidence that a referral for a mental health assessment could have been expedited and there would have been more scope to make telephone calls, do more and sit down with Bailey.[254]

243. I note that the experts were not critical of Ms Hyde's decision to raise the Mandatory Notification after having heard what Bailey said in his interview. Dr Eagle, however, was of the view that Bailey was unlikely at "*imminent risk*".[255] Dr Eagle does not think that the decision to place Bailey in the observation cell was consistent with the principle of least restrictive care. The evidence clearly establishes that at that time at Kariong CC, the policy in relation to least restrictive care was not complied with (as an assessment cell was considered the only option for inmates who were deemed at risk of suicide). This was confirmed by Mr Dolling, Mr Cargill, Ms Hyde and others. It is

[250] Ex 1, Vol 5, Tab 63, p. 23 of 34.
[251] Transcript 7/5/21 T32.30-35.
[252] Ex 24.
[253] Exhibit 13.
[254] Transcript 7/5/21 T36.35-37.12.
[255] Transcript 20/10/21 T307.11.

unfortunate then that at the inquest there was an attempt by some witnesses to suggest that there had been an assessment in relation to the cell when Bailey was first placed into it. However, Ms Thompson and RN Georgiou did try to assess options (to no avail) given the attitude of the senior correctional officers.

244. Dr Furst acknowledged that there were other less restrictive placement options but that those options do not necessarily protect against suicide. He referred to a 10 year NSW study from 1995 to 2005 which found that 22% of deaths occurred in shared cells, and out of 91 deaths, three had occurred in safe cells.[256] Professor Large proffered that placing a suicidal inmate in a shared cell offered a moderate degree of safety, and that there is a threefold increase of risk with single cell placement, but he was not aware of a study comparing a camera cell.[257] Dr Eagle commented that placing a person in an observation cell is really incapacitating someone's suicide risk. She said:

> "*You're just simply getting rid of access, and you may be making the problem worse, you may be increasing the distress, increasing the hopelessness, preventing them from addressing whatever is driving that motivation to end their life, so I just think it's a short-sighted strategy to address a much more complex problem, just locking someone up, and that's why we have the least restrictive option….in psychiatric settings, but we need to look at the least restrictive option in the circumstances, in the context of being able to provide appropriate psychiatric support"*.[258]

245. Dr Eagle made a very valid point as to why a review team should have at least one member with expertise as to suicide risk and mental illness. She said this:

> *"I just wanted to make the comment about the RIT process generally, in psychiatric settings or mental health settings we don't isolate or seclude people for suicidal behaviour, so this is an extraordinary response that is unique to correctional settings, to lock a person in seclusion or in isolation based on an assessment of risk, which is already known to be fraught with uncertainty; the assessment of risk, I mean, of suicide.[259] In those circumstances I think it would be a minimum that there should at least be somebody who has the skills and expertise to assess suicide risk and mental illness on the panel that makes the decision as to whether this extraordinary step that is considered to be highly distressing to most inmates, in my experience, and not considered to be therapeutic or indicated in any other*

[256] Transcript 20/10/21 T264.43-265.6.
[257] Transcript 20/10/21 T265.10-20.
[258] Transcript 20/10/21 T265.40 – 266.6.
[259] Pr Large agreed with Dr Eagle and said that "*outside of Corrective Services we never isolate patients because of sociality, in fact there's a policy specifically against that*." (Transcript 20/10/21 T273.43-45).

psychiatric setting. You would expect that there should be someone with mental health training on that panel to help make that decision...[and further] the purpose of the ISP is to actually determine the appropriate interventions that a person needs to manage their suicide risk. It's not just a ticket to go into an assessment cell, sit there them [sic] until they get better and pull them out, and as part of that process it's anticipated in the policy that a mental health referral may need to be made and the specific psychological or mental health interventions might be needed, and in that case you don't know what you don't know, so I'm not sure how a person without mental health training or understanding would be able to identify those strategies in those circumstances."[260]

246. Counsel Assisting asked Dr Furst whether in his view, a RIT team should be required to have either a psychologist, nurse or a person who is trained in mental health and he replied:

> "*Yes, that is a good question. I think on both sides, like given that Corrective Services has access to psychologists in their ranks and given that Justice Health had access to mental health nurses and psychiatrists at times, depending on staff levels and availability, it would be I'd say preferable for that composition to be a mental health nurse or a psychologist, if available, that type of wording [in the policy]. But it [the policy] certainly doesn't specify that right now*."[261]

247. Professor Large and Dr Furst were of the view that once a decision had been made that an inmate was at risk of harm, the RIT review team would need something significant to change that assessment. Professor Large did point out that in the community system where a patient is placed in isolation (for protection of others), the process to place them in such accommodation is significant whereas the process to remove them from such accommodation is far less so.

248. RN Georgiou said in her evidence that Bailey "*couldn't clearly outline that he wasn't at risk, he couldn't clearly deny that he wasn't [sic] suicidal or that he wasn't [sic] going to hurt himself*."[262] She said he could clearly articulate his desperation to get out of the cell. She was asked whether Bailey could not articulate his lack of risk of self-harm because he was pre-occupied with his distress over being in the assessment cell.[263] It appears that RN Georgiou placed weight on the fact that Bailey was calm when she gave him medication at 4pm on 4 November 2019, and that on the morning of 5 November 2019 when Bailey told her he did not have chest pain but wanted to get

[260] Transcript 20/1021 T270.25-38 and T270.46-271.6.
[261] Transcript 20/10/2021 T273,33-39.
[262] Transcript 7/5/2021 T14.25-30.
[263] Transcript 7/5/2021 T14.36-42.

out the cell, "*he was calm, he was communicating he wasn't completely you know frantic and desperate in his pleas for the entirety [of his 10 minutes*[264] *in the clinic]*". However, in her statement RN Georgiou said that Bailey's pleas not to be returned to the observation cell were the most intense she had ever observed in a patient.[265]

249. The fact that Bailey was unable to articulate the right answers to convince the RIT review team that he was not at risk was raised by Dr Eagle [see para. 234 above]. I agree with Dr Eagle's opinion that there were other placement options available and as Counsel Assisting submit, Bailey was denied the opportunity of those options that might not otherwise had occurred had there been compliance with CSNSW policy in the conduct of the RIT review team meeting.

The escalation following RIT review

250. While the RIT review meeting continued in his absence, Bailey spent about 20 minutes in the accommodation unit unsupervised before being taken back to cell 41 by three officers. During the 50 minutes that Bailey was absent from the cell, officers searched it and removed food and plates. At about the time Bailey was collected from the accommodation unit, an officer entered Cell 41 and left food for Bailey on the bench. When Bailey was returned to the cell, he underwent a strip search, during which CCTV footage shows an officer dropped something white on the floor and after the officers left at 11:52am, Bailey put the white object in his mouth.

251. Within three minutes of being left alone in the assessment cell, Bailey started making CICs. At 11:55am, Bailey made a CIC asking to see the nurse saying that he was vomiting (whilst he can be heard gagging and burping). The officer told Bailey to use the toilet to vomit and that someone was coming up to see him. In the next call at 11:57am, Bailey said "*I can't breathe*". The officer told Bailey to "*relax a bit"* and *"try and breathe properly*". At 11:59am, Bailey was gagging and the officer told him to slow his breathing and that he was having a panic attack. At 12pm, Bailey says "*I can't breathe*" and the officer said "*Mate, as, as I said, you're probably having a panic attack mate you need to slow your breathing down and you…this intercom is for emergencies only*". Bailey replied, "*[t]his is an emergency I can't fucking breathe. Help*".[266]

252. Bailey made another CIC which was unanswered, and he lay on the floor in foetal position. Officers attended the cell and stood near Bailey while he lay on the floor and

[264] Transcript 7/5/2021 T15.25.
[265] Transcript 7/5/2021 T16.22.
[266] Ex 11, Items 14-18.

then they left. Bailey then got up off the floor and at 12:03pm a female officer called Bailey and told him that "[*t]he nurse is on her way*".[267]

253. RN Georgiou says that within minutes of returning to the clinic after the RIT review meeting, she received a call from correctional officers saying that Bailey was making CICs and asking to see her.[268]

254. At about 12:05pm, correctional officers and RN Georgiou attended (but did not enter) the observation cell. While Bailey knelt on the cell floor, the officers spoke to him through the internal cell door. RN Georgiou said that she also spoke with Bailey. She said she tried to distract Bailey and encourage him to take deep breaths. They left and Bailey got up and continued to make CICs at 12:06pm. RN Georgiou said that she thought her presence was probably only making things worse, so after a couple of minutes she left and watched Bailey on the monitor for 25 to 30 minutes to make sure he was okay before going back to the clinic.[269]

255. At 12:06pm, during a CIC Bailey said "*I can't breathe*" and the officer told him "*[m]ate, you've just been seen by the clinic*". Bailey gagged and asked for "*help*". He again made another CIC and said, "*I can't breathe*" and was told to "*take deep breaths*". Bailey says "[*h]elp*" and he is told that the nurse had just seen him. Five more CICs occurred with Bailey saying he could not breathe and he needed help. The officer kept telling Bailey that the nurse had seen him and there was nothing she could do, and that he just needed to relax and try to calm down and slow down his breathing.[270]

256. The CCTV footage suggests that although Bailey pressed the CIC button numerous additional times, there are no records of such on the CIC log or they were answered without response. Mr Lloyd, who last dealt with Bailey's call at 12:08pm,[271] was asked by Ms Lewer whether he accepted that the manner in which he and some officers dealt with Bailey on the CICs could be described as contemptuous. Mr Lloyd rejected this suggestion completely and said:

> "*I don't agree whatsoever. You have to understand this environment we - we're in. From the minute we walk in the door to the minute we leave, on most days you're bombarded with abuse and knock ups, and requests, and lies, and threats of harm, and threats of assault. It's non-stop. If you can understand that after a long period of time of Mr Mackander knocking*

[267] Ex 11, Items 19-20.
[268] Transcript 7/5/2021 T37.15-25.
[269] Transcript 7/5/21 T37.25-37.
[270] Ex 11, Items 21-28.
[271] Ex 11, Items 24.

up, knocking up, knocking up, knocking up - and we had seen him a number of times. The nurse had seen him, they deemed him to be okay. That it - it - you're - yeah. Your compassion can be bashed around, if you know what I mean? It's - you can't always be helpful to someone who doesn't seem to want to help themselves….. I was just trying to tell him how it is. And that's probably what he - what he needed to hear, hear the facts. That if he - if he tries to behave himself, and try to look after himself and do the right thing, then he might get out of the observation cell. But by yelling and screaming continually, it's not helping his cause whatsoever, and I was just trying to tell him how it is. And most of the officers in here that I've read are probably trying to do the same thing".[272]

257. Ms Lewer asked Mr Lloyd whether it was the case that Bailey had to behave himself to get out of the observation cell and Mr Lloyd replied: "*Well, obviously, yeah. If he's behaving in an irrational manner, do you really think it's - it's - it's in his best interest to let him out into the main - into the general population where he could hurt himself? No*."[273]

258. RN Georgiou said that when she left the office, she watched the monitor at a point where Bailey "*was no longer putting his fingers in his mouth and he did appear a bit more settled*".[274] This must have been during the period after the 12:11pm CIC when the officer told Bailey, *"[y]ou're fine, the nurse has seen you*".[275] RN Georgiou conceded that the length of time she indicated she viewed Bailey must be incorrect, given CCTV records indicate that she left the observation cell at 12:07pm and returned at 12:26pm.[276] If she thought Bailey had settled, the only time that could have been was between 12:11pm and the 12:17pm CIC, which would suggest that any viewing of the monitor was for a period of about five minutes. She said that she did not have audio when she was looking at the monitor, which seems to be at odds with evidence that the monitor was in the same room where the officer attending to the CICs was located.

259. The CIC at 12:17pm is five and a half minutes duration. Bailey asked for help, said he was choking, repeatedly pleaded and prayed for help, was retching and said "*I can't breathe*". The call was unanswered and at 12:24pm, Bailey returned to lying on the floor.[277] RN Georgiou said that when she returned to her office the telephone was

[272] Transcript 19/10/21 T115.42-116.1, T116.11-17.
[273] Transcript 19/10/21 T116.21-23.
[274] Transcript 7/5/21 T37.47-48.
[275] Ex 11, Item 27.
[276] Transcript 7/5/21 T84-85.
[277] Ex 11, Item 29.

ringing. She answered the telephone and was informed by a correctional officer that Bailey was laying unresponsive on the cell floor.[278]

260. RN Georgiou retrieved her emergency bags and attended the observation cell. RN Georgiou said that she did not recall seeing vomit, there was not vomit everywhere and she did not smell vomit. She said that although she had seen Bailey putting his fingers down his throat, she had not seen him vomiting.[279]

261. RN Georgiou carried out an examination of Bailey. His observations were normal and she said that when she tried to open his eyes, he squinted them shut. She said Bailey was medically okay. Though there was nothing apparently concerning to her about Bailey, RN Georgiou placed a Guedel airway device in Bailey's mouth and throat as she said it was standard training to put an airway in if someone is presenting as unresponsive.[280] RN Georgiou said that this was a clinical decision she made in case something changed.[281] In her statement, RN Georgiou indicated that placing the device may potentially have encouraged Bailey to talk with her. She said in her evidence that it was not her intention to place the device to make Bailey respond, but rather it was a by-product that could have occurred. She placed the device without any response or reaction from Bailey.[282]

262. After Bailey was in the recovery position on the mattress on the bench in his cell, RN Georgiou left the cell and telephoned a Remote Off-site and After Hours Medical Services ("ROAMS") GP. ROAMS is an on-call system so that medical advice is available to Justice Health staff on a 24/7 basis. RN Georgiou and the doctor agreed that RN Georgiou should call an ambulance. Whilst she was on the phone to the ambulance service and was advised that it was a very busy day and there would be a long wait, she received a radio-call from a correctional officer who advised her that Bailey had opened his eyes and was responding. As such, RN Georgiou ceased calling an ambulance and attended the cell. However, when she arrived Bailey was again unresponsive so she recalled the ROAMS doctor and after further discussion, called an ambulance again.[283]

263. Bailey had continued to remain apparently unresponsive for two hours. During that time, RN Georgiou mostly remained in the observation cell (other than for periods of a

[278] Transcript 7/5/21 T37.45-38.5.
[279] Transcript 7/5/21 T61.20-26, T62-63.
[280] Transcript 7/5/21 T39.15.
[281] Transcript 7/5/21 T40.22.
[282] Transcript 7/5/21 T40.30-40.
[283] Transcript 7/5/21 T43.35-44.20.

couple of minutes, 20 minutes and 15 minutes when she was speaking with others and making arrangements for paramedics to attend). The paramedics attended the cell at 2:15pm. According to RN Georgiou, the lead paramedic spoke to Bailey, asking him to open his eyes and speak with him. When Bailey did not do so, he squirted saline up Bailey's nose and into his eyes. Bailey then sat up and complained that he had chest pain and the paramedic said "*[n]o, you're fine*" and the paramedics left.[284] Bailey said that he would like to have a shower and asked for a towel. RN Georgiou then left.

264. A couple of minutes after their departure, Bailey sat up and leant over the toilet. Officers attended, removed a white item and left again. The white item was likely a piece of polystyrene cup which Bailey was from time to time ripping up and swallowing.

265. Bailey made a CIC at 2:30pm which was answered by an officer who told him: "*The nurse has seen you. Two ambulance officers have been called in to see you. There is nothing wrong with you. We will not be doing anything further for you. Stop knocking up*".[285] RN Georgiou did not know that had occurred.[286] The CCTV shows Bailey pressing the CIC button, but there is no response.

266. At about 2:40pm, Bailey covered the observation cell camera with toilet paper. An officer attended and removed the paper and another officer spoke to Bailey and left. Again, Bailey pressed the CIC button with no response.[287]

267. At 2:50pm, Bailey again covered the camera with toilet paper and again the officers attended and removed the paper but this time they also removed Bailey's blanket. At this time, Bailey was back lying on the floor. Another officer arrived and splashed water on the cameras to remove the paper and stepped over Bailey who remained on the cell floor.

268. At 2:57pm, Bailey got up off the floor and over the next half hour continued to press the CIC button repeatedly with no response. Officers attended twice and left.

269. At about 4pm, RN Georgiou attended the cell and dispensed medication to Bailey. RN Georgiou said she was not told that Bailey had been vomiting between the time the paramedics left and this time, and she said that had she been informed she would have attended to Bailey. She agreed that she could have attended Bailey and if the symptoms were arising from anxiety and distress she could have contacted a

[284] Transcript 7/5/21 T44.35.
[285] Ex 11, Item 30.
[286] Transcript 7/5/21 T45.25.
[287] Ex 12.

psychiatrist or doctor to obtain medication for Bailey to stop the vomiting and alleviate his symptoms. She said that the correctional officers should have called her.[288]

270. RN Georgiou's clinical notes of the day indicate that she spent a substantial amount of time and effort to ensure that Bailey was medically safe whilst he was in the assessment cell. It would appear that after this time, RN Georgiou was not called upon by any correctional officers and it would appear that they did not answer any of the many numerous CICs that Bailey apparently made throughout the next two hours.[289]

271. RN Georgiou's further clinical notes for the day set out a well-documented record of the medical care she provided to Bailey:

> *"1215 Nursing: Phone call from compound. Pt knocking up asking for nurse – attend pt observations cell. Pt had fingers down his throat attempting to vomit. Attempted to discourage. Pt stated he couldn't breathe – Pt pink, alert, walking around cell talking in full sentences. Pt refused to sit down and take slow deep breaths – decided to leave cell area as pt becoming more upset – watched on camera in room near door for lengthy period (25-30/60 [minutes])- decided to go back to clinic – immediately received a phone call to say pt lying on floor unresponsive. Attended clinic [sic] – pt breathing, reacting to pupil RV*
>
> *1232 PEARL BP 131/79, [0xygen sat] 97%, RA; HR 101 reg, T36.1, BSL 7.1 mmol/L – pt picked up by CSNSW and placed on bed in recovery position. Pt kept eyes closed and resisted eye opening, hemodynamically stable [with] good air entry*
>
> *1245 Decided to place a guedels airway in to ensure airway remained open. Pt tolerated same – an officer dropped a pan near cell door and pt reacted – obs BP 128/178, HR 95 reg, [oxygen sats] 98% RA BSL 6.8 mmol/L. Pt talked to at length about opening eyes and sitting up. Nil concerns for pt as PEARL – pt spat guedels and moved back a little from his spit that he dribbled from mouth. Contacted MO Dr Lyndon to discuss- [query] need for ambulance decided to contact. Whilst waiting pt moved, ended call to ambulance - attended cell again – pt shut eyes again, attempted to engage pt again*
>
> *1300 obs temp 35.9 [degrees Celsius], BP 129/81, HR 92 reg PEARL BSL 5.8 mmol/L [oxy sats] 98% RA. Sat with pt encouraging to open eyes – contacted ambulance after again discussing with ROAMS*
>
> *1400 GP - obs BP 126/79; T 36.3 [degrees Celsius] - HR 79, BSL 5.8 mmol/L, PEARL. Guedels no longer insitu*

[288] Transcript 7/5/21 T45.50 – 47.1.
[289] See Ex 22.

1415 Ambulance arrived – saline to eyes with syringe, pt woke and became teary saying he had chest pain – advised pt he is fine and they left centre with nil further [treatment] required – pt sitting up alert and talking, left cell

1605 Nursing: attended cell to give pt his supervised meds –same administered. HPNF updated and sent to AHNM with telephone handover of pt given in detail".[290]

272. A HPNF written at 3:21 pm requested that CSNSW staff monitor Bailey and report any signs and symptoms to Justice Health.[291] The signs and symptoms were typed in capital letters:

> "*SUICIDAL IDEATION _ ACTIVE RIT – OBSERVATION CELL WITH CONSTANT CAMERA. OBSERVE FOR SEIZURE LIKE ACTIVITY AND SELF HARM."*

273. In the section regarding what CSNSW staff need to do if such observations are made, RN Georgiou wrote:

> "*CONTACT AHNM– 13000ROAMS AND AMBULANCE. Encourage positive behaviours & Attempt de-escalation*."

274. At 4:46pm on 5 November 2019, RN Georgiou sent the HPNF to the AHNM and her Nurse Manager[292] and she had telephone calls with both of those people providing a detailed handover to them before leaving the compound for the day. RN Georgiou had intended to make a referral for Bailey to be assessed by a Justice Health Nurse and had commenced transfer documents to have Bailey transferred to a centre with better medical facilities. Though she in fact did not make any referral for Bailey to be assessed by a mental health nurse, she gave evidence that even if she had, any such assessment would not have occurred that or the next day. In relation to the transfer papers she incorrectly thought that an inmate could not be transferred whilst on a RIT so it is unclear whether she intended that on 6 November 2019 Bailey would be removed from the RIT to affect his transfer. RN Georgiou was not rostered to work on 6 November 2019 and expected that the referrals would be actioned by the next nurse on duty.

275. RN Georgiou said that in her opinion, Bailey should never have been at Kariong CC as he had a very recent history of being on a RIT, had seen a psychiatrist, was starting

[290] Ex 1, Vol 3, Tab 43, pp. 62-64.
[291] Ex 1, Vol 4, Tab 46.21, Health Problem Notification Form.
[292] Transcript 7/5/21 T49.15; Ex 24.

medication and that Kariong CC is an isolated site with not very good services and with insufficient nursing hours.[293] RN Georgiou said there was no afternoon nursing shift, no mental health nurse and no drug and alcohol services which raised alarm bells in her for Bailey.[294]

276. Previously, RN Georgiou had a local arrangement whereby she would vet intended transferees to the centre and indicate to the CSNSW Kariong CC manager her opinion as to whether Kariong CC was inappropriate given the medical needs of an inmate. She had taken maternity leave and upon her return learned that this practice was no longer in place.

277. The expert witnesses were asked to comment upon the escalation of Bailey's conduct in the observation cell. Dr Furst agreed with Mr de Mars that RN Georgiou could have commenced a referral to a mental health nurse on 4 November 2019 when she learned from Ms Hyde that Bailey was at risk of suicide.[295]

278. Ms Lewer asked whether further training should be provided to correctional officers to equip them to deal with people who are on a RIT and people who are in acute distress. Dr Eagle said:

> *"…this is a difficult question for me to answer because I think the process is inherently flawed, so I'm going to just [say] that right from the outset, and I don't know what level of training you can have to determine what circumstances it might be okay to do something that's counter-therapeutic, but I suppose you could at least provide some mental health training and some risk assessment training, so that officers have knowledge of evidence based risk factors, when might be appropriate to urgently refer someone for mental health assessment, how to identify risks relating to a person's presentation or mental state, how to respond in a supportive way rather than a punitive way when someone is in distress, so I guess those sorts of things might be able to be covered, but I think the issue here is that this practice is not used as a last resort and it's used to protect, basically, Corrective Services from an adverse event rather than for the benefit of the person who's in distress, and I think that's an inherently conflictual role that the person has when they're making that decision…., I think the training could be done in a few days or in a week. If it was targeted and done in the sort of comprehensive way, you know, I think there are other disciplines that have mental health training like police and other sort of services that could at least give sufficient training so that the person can operate in a*

[293] Transcript 7/5/21 T51.12-28.
[294] Transcript 7/5/21 T51.40-50.
[295] Transcript 20/10/21 T293.45-294.6.

> *safe and effective way and refer on to appropriate people who have more exercise where appropriate, and that could be done any time I suppose up to sort of a week's training in those sorts of workshop formats*."[296]

279. Dr Furst added that the CIC system is not designed for RIT engagement as it is supposed to be used for emergencies. He said:

> "*I do think that the best way forward is to have one on one support or access to people that can come in and counsel someone and support them as a clinical situation, not through a buzz up system across the state*."[297]

Bailey is taken to hospital on 5 November 2019

280. At about 4pm on 5 November 2019, Bailey made a CIC and asked for something to eat. He was told that he has been quite sick and throwing up so food was probably not a good idea and to settle down. Bailey said he could hardly breathe and the officer replied, "*I know mate, but um, you're doing okay there, so just see if you can relax for a while, okay?*". Bailey told him "*I'll try, I'll try my best*". The officer replied, "*[g]ood on you mate, thank you*".[298]

281. At 4:20pm, Bailey ran at the door, hitting his head. Officers attended and spoke to Bailey for several minutes and then left. At 4:30pm, Bailey made a CIC and spoke with Mr Cargill. He asked if he could have a shower. Mr Cargill wanted Bailey to clean the cell before having a shower and he agreed to do so.[299] A bucket and mop was taken to the cell and Bailey mopped the cell, after which the items were collected and Bailey was given a towel. He took a shower and then used the towels to dry the floor.

282. At 4:55pm, Bailey made a CIC and asked to talk to the officer for a second. Bailey was told that the officer was a bit busy but that he would come around and for Bailey to be patient.[300]

283. Mr Cargill attended the cell shortly after 5pm and collected the towels. Bailey told Mr Cargill that he was in severe pain as he had swallowed four batteries and four razor blades when he was in the accommodation unit earlier that day.[301] Officers respond to this information and ascertained that Bailey had been left unsupervised in the accommodation unit for 20 minutes during the RIT review meeting. They attended

[296] Transcript 20/10/21 T285.29-286.10.
[297] Transcript 20/10/21 T286.30-35.
[298] Ex 11, Item 31.
[299] Ex 11, Item 32.
[300] Ex 11, Item 33.
[301] Ex 1, Vol 7, Tab 93, Statement of Peter Cargill, [17]; Ex 1, Vol 4, Tab 46.6, IRM 245914.

John Brown and asked him to check their cell to see if any batteries and razor blades are missing and he said that they were not. Arrangements were made for Bailey to be taken to hospital.

284. Bailey again pressed the CIC button without effect, until he returned to lying on the floor of the cell at about 5:15pm. After a couple of minutes, Bailey got up and made another CIC, complaining that his stomach was "*fucking aching*" and that he was in pain. Bailey was told by the officer that he was busy doing other things.[302] There were two more CICs where Bailey complained of an aching stomach and being in pain and asked what was happening.[303]

285. At 6:07pm, Bailey was removed from the cell, handcuffed and shackled, placed in the prison van and escorted from Kariong CC to the ED at the Hospital by Mr Slingsby and Mr Uerata.

Escort assessment

286. The documents contained in the escort briefing kit were much the same as the previous day, except Mr Cargill had changed section 3 of the summary on the 'Escort Assessment' to read "*Impulsive inmate with suicidal ideation. Has 'cried wolf' several times. Placed on RIT by psychologist*". At section 8 of the s. 24 order, Mr Cargill typed "*[t]o be closely monitored/supervised at all times, on active RIT*".[304]

287. Mr Cargill said he used the term "*cried wolf*" because on Bailey's return from hospital the previous night, Bailey had asked about his medication and had not mentioned the pain so Mr Cargill thought that he was not "*fair dinkum*".[305] This demonstrates a fundamental misunderstanding of what a panic attack feels like and suggests that by asking for medication, he thought Bailey was a malingerer. However, I accept Mr Cargill's appraisal that Bailey's feigned unconsciousness for over two hours that day was another indication that he was not necessarily genuine in his presentation.

288. Mr Cargill did not believe Bailey's claim that he had swallowed batteries and razorblades but was compelled to err on the side of caution and have Bailey examined at the Hospital. Mr Cargill denied that using the term "*cried wolf*" was suggesting that Bailey was not suicidal; however, he accepted that someone reading what he had

[302] Ex 11, Item 34.
[303] Ex 11, Items 35-37.
[304] Ex 1, Vol 4, Tab 46.26.
[305] Transcript 6/5/21 T6.7-28.

written might think he was suggesting that.[306] Mr Cargill said that he was indicating to the escort officers that Bailey was not trustworthy or reliable.[307]

289. Bailey was taken to the Hospital and escorted from the van to the door of the ED again with Mr Slingsby being the closest escort officer and Mr Uerata being at a distance [redacted] Mr Slingsby did not take hold of Bailey's handcuffs.

Medical examination and discharge from Gosford Hospital ED on 5 November 2019

290. An issue in the inquest was whether Bailey's examination at the Hospital on 5 November 2019 was appropriate and expert reports were obtained by those assisting the coroner. That issue was resolved by correspondence and receiving statements from the treating doctor Dr Stephen Cameron.[308] When Bailey was triaged a chest x-ray was ordered and he then saw Dr Cameron, who asked Bailey why he was at the Hospital. Bailey told him that he had swallowed the batteries and razor blades. Dr Cameron examined Bailey and adjunct to that examination he used a metal detector wand over Bailey's abdomen and determined that there were no metal objects causing any obstruction and he did not proceed with a chest x-ray. Dr Cameron discharged Bailey with the instruction that he should return to the ED if he developed any signs of obstruction or perforation.[309]

291. Dr Cameron agreed with the experts' criticism that his clinical notes were insufficient and he undertook to improve his note making. He explained that he had on occasion used the metal detector wand on children who had attended the ED as the result of swallowing lithium batteries and it was a useful non-invasive examination tool. However, he accepted that it was inappropriate to use the metal detector wand on an adult as such use had not been validated. In hindsight he conceded that he should have proceeded with the chest x-ray but that had it been performed and shown foreign bodies in the abdomen, his management plan for Bailey would not have altered. Whilst one of the experts was critical that Dr Cameron had not undertaken a mental health assessment, Dr Cameron explained that after speaking with Bailey, even though he reported swallowing objects he did not illicit any issues to warrant such an assessment. Given the conclave evidence taken at the inquest I accept that Dr Cameron's judgement in that regard is not one which should be criticised.

Bailey's fall

[306] Transcript 6/5/21 T6.6-43.
[307] Transcript 6/5/21 T7.4.
[308] Ex 12, Tab 2, Statement of Dr Cameron dated 29 April 2021; Tab 3.
[309] Ex 12, Tab 3, Statement of Dr Cameron dated 20 May 2021, [5].

292. After Bailey's discharge, he returned to the CSNSW van, walking in similar fashion as when he arrived. Unlike on 4 November 2019, Mr Uerata did not open the van door but rather Mr Slingsby did with Bailey standing "*shoulder to shoulder*" at the door next to him.[310] It was while Mr Slingsby was distracted opening the door that Bailey instantly stepped to the nearby wall and propelled himself over. Mr Uerata, seeing Bailey step back and move his head to the left to look at the wall, instantly called out to Mr Slingsby. However, Bailey stepped quickly away and Mr Slingsby could not grab Bailey to prevent his flight.

293. Both Mr Uerata and Mr Slingsby gave evidence that they did not appreciate at the time that there was an eight metre drop below the wall. Mr Slingsby jumped onto the wall to follow Bailey but it was only when he was on top of the wall that he saw how high the ambulance ramp was above ground level. Mr Slingsby said that he thought there was a garden on the other side of the wall. He explained that entering the ramp and travelling to the ED entrance was quite deceiving and that there was no sense of how elevated they were.[311] Bailey most likely was under the same misapprehension that beyond the wall was ground level.

294. Neither Mr Slingsby nor Mr Uerata had any sense that Bailey was a flight risk and I accept that Bailey gave them no reason whatsoever to give them cause to suspect he might be.

295. Mr Uerata said that he was told by Mr Cargill to keep an eye on Bailey because he was distraught and he was crying when he was getting into the escort van at Kariong CC.[312] Mr Uerata said that when Bailey was at the Hospital, he was fine.

296. Mr Slingsby said that when he had arrived at work on 5 November 2019, he went to Bailey's cell and at that time the nurse and the ambulance paramedic were in the cell. His next involvement was being directed by Mr Cargill to look at CCTV footage to ascertain whether Bailey had been left in the accommodation unit that day. After seeing that Bailey had, he and Mr Cargill attended and spoke to John Brown about whether there were any batteries and razor blades missing from the cell. He was next involved when Mr Cargill tasked him to escort Bailey to the Hospital.[313]

[310] Transcript 20/10/21 T245.4.
[311] Transcript 20/10/21 T222.25-30.
[312] Transcript 20/10/21 T240.48-251.9.
[313] Transcript 20/10/21 T212.48-213.50.

297. Though Mr Slingsby did not recall doing so, he said he would have read the s. 24 and escort assessment documents prepared by Mr Cargill.[314]

298. Counsel assisting asked Mr Slingsby whether in his view the requirement for an escort officer to provide close monitoring required that officer to have hold of an inmate. Mr Slingsby said:

> *"From the policies and procedures with escorts I've done in the past,* [redacted] *Normally you would assess each inmate because they're all different. If Bailey was - if Bailey had come out of the hospital and he was aggressive, I probably would have hold on - I'm not sure I would have held on to the cuffs. But my - my way of thinking, as I said doing escorts before, putting a patient - sorry, an inmate into the back of a vehicle, I didn't want to put any extra stress on Bailey putting him into the van. So that's one of the reasons I didn't hold on to his handcuffs on the way out."*

299. Mr Slingsby explained that there is [redacted]. Mr Slingsby said that it is quite claustrophobic and that he has experienced inmates trying to self-harm in it. He said he was concerned about Bailey in that regard. He sought to keep an inmate as calm as possible in order to enter the van. Mr Slingsby said that as they were walking to the van he did not notice any changes to Bailey that caused him concern and to take hold of him.

The CSNSW investigation

300. Mr Hovey said that the CSNSW investigation was impacted by one investigator being so traumatised by the circumstances involved in Bailey's death, and the other by listening to the CIC audio to transcribe the calls, that neither had been able to continue working.

301. The CSNSW investigation proceeded on the basis that Bailey had in fact swallowed batteries and razor blades, however this inquest has investigated that issue further. The evidence demonstrates that whilst that was not the case, at some time (and it is unknown whether it was before or after Bailey was placed in the assessment cell), Bailey had ingested a number of small rocks that were located at autopsy. Also retrieved were pieces of plastic and polystyrene that Bailey had apparently consumed, as seen on CCTV, in the assessment cell. Further, pieces of paper were located at autopsy.

[314] Transcript 20/10/21 T215.29.

302. The CSNSW investigation had access to the CSNSW computer system and the hard copy of the inmate's management file. On the computer system, there are case notes (known as OIMS) and Incident Reports (known as IRMs); however, there are no psychologist reports and no Justice Health documents. The HPNFs are kept on the hard copy file but not on the CSNSW computer system. Mr Hovey said that although the investigator can see the time that an OIMS report is created, when the document is printed out that detail is not printed. Mr Hovey said that an investigator involved in a CSNSW investigation into a death in custody does not have access to Justice Health records. Rather, the investigator receives a letter summarising the history of the inmate from a senior person in Justice Health.

303. Mr Hovey said that as the escort policy [redacted], there had been no breach of policy by officers Mr Slingsby or Mr Uerata on 5 November 2019. Mr Dolling and Mr Cargill's opinion that Bailey should have been under physical restraint was met by Mr Hovey's response:

> "*Whereas Mr Cargill and Mr Dolling may well have had an expectation, if that is not communicated appropriately to the escort officers, then it's just a subjective view that that's what should have happened, in my opinion.* [redacted]

304. I share that view. If a senior officer who completes an escort assessment considers that the risk warrants the inmate being physically restrained by the escort officer then that officer should write that opinion on the escort documents – both the s. 24 and the escort assessment - and give that instruction at the verbal escort briefing.

305. Mr Hovey's report included recommendations regarding the correctional officers' management of Bailey while he was in the assessment cell. The recommendation was made in November 2020 and reads:

> "*Ultimately, what these matters indicate is a systemic issue within CSNSW regarding the training and services available to CO's to recognise serious issues with inmates and provide an appropriate response.*
>
> *A primary recommendation of this report is that CSNSW review, update and improve the training provided to CO's not just to identify inmates suffering mental health issues, but in how they provide distress tolerance assistance and review inmates' cell placement needs, in order to comply with the CSNSW duty to take reasonable care of the safety of*

the inmates".[315]

306. Mr Hovey said that since February 2021, CSNSW investigations delve further into systemic processes (such as an inmate being placed on a RIT) so that rather than describing the sequence of events, the investigation looks into the appropriateness of the process. For deaths where an inmate is on a RIT, a CSNSW investigator would now interview members of the first and last RIT review teams.[316]

307. Mr Hovey agreed that a CSNSW investigation into a death in custody was concerned with compliance with the *Crimes (Administration of Sentences) Regulation* ("the Regulation"). Mr de Mars asked whether Mr Hovey had regard to the requirement that inmates receive two hours of exercise per day (which applies to inmates other than those confined in a cell under ss. 53 or 56 of the *Crimes (Administration of Sentences) Act 1999,* which relate to inmate discipline and is not applicable to Bailey's situation in an assessment cell). Mr Hovey replied:[317]

> "*In my experience, it's not easy to facilitate and supervise exercise over an inmate who's held either in a safe cell or a secure cell, as in segregation, for example, it would require no contact with other persons, a search of that area would have to be undertaken to ensure that there was nothing that could be used or secreted for self-harm. It's not unusual, in my experience, for an inmate who is being managed under a RIT to not receive the full period of exercise as you describe*."

308. Though Mr Hovey is not quite right that a RIT inmate would necessarily have no contact with others, the point he makes is that although the Regulation mandates daily exercise, inmates do not always receive it. It seems that if systemic use of assessment cells means that inmates are housed in breach of the Regulation then those systems need to include staffing levels and facilitating access to areas so that the Regulation is complied with.

309. Ms Alderton asked Mr Hovey whether he would revise paragraph 61 of his report having learned that the correctional staff did not refer Bailey to Justice Health when Bailey used the CIC system requesting same. He agreed that it was incumbent upon correctional staff to make that referral, rather than conduct their own assessment as to whether or not medical attention was warranted.

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[315] Ex 1, Vol 4, Tab 46, [122]-[123].
[316] Transcript 21/10/2021 T 364.15-20.
[317] Transcript 21/10/2021 T 367.22-28.

Family members contacting CSNSW

310. The unsuccessful attempts that were made by Bailey's mother Tracy to speak to a staff member at Kariong CC on 4 November 2019 and 5 November 2019 were addressed by Mr Murrell. On 4 November 2019, the phone call at 2:16pm was handled by a staff member named Sharon, who was advised by Ms Hyde that she could not speak to Tracy. On 5 November 2019, Tracy made three telephone calls. The first was at 2pm, the second at 2:25pm and the third at 2:32pm. The first call no-one answered. The second call was to the governor at Kariong CC, and she was transferred to the Justice Health clinic at Kariong CC but the nurse at the clinic declined to speak to her. The third call was to a liaison officer at Long Bay CC who advised Tracy that a form to secure Bailey's consent for someone to speak to her would be sent to him. She said she would call Tracy back but she did not.

311. Mr Murrell agreed that Tracy had a legitimate reason to call given that Bailey was on a RIT.

312. As at present, there has never been any CSNSW policy in relation to CSNSW staff speaking with family members. Mr Murrell said that there was information in the Family Handbook and on the CSNSW website. He conceded that the Handbook did not provide sufficient guidance as to how a family member might communicate information about an inmate who was at risk of harm.

313. Mr Murrell thought that Tracy's call to Kariong CC that was answered by the administrative person known as Sharon could have been escalated to someone in charge.

314. Dr Sarah-Jane Spencer was also asked questions about Tracy's attempts to speak with someone at Justice Health. In particular, she was asked about RN Georgiou's evidence that although she did not receive a call or was not made aware of a call to the clinic on 5 November 2019, she would not have spoken to Tracy in any event because "*it's a referral to a client liaison officer where … they would … have a release of information signed and I would be asked questions that way. There's no … scope or option to speak to family members directly*".

315. Dr Spencer commented on RN Georgiou's position thus:

> *"I think I'd echo what Professor Large said, which is that there is - and I think we've heard it from the psychologist who gave evidence earlier today; that I think there is general misunderstanding and fear about*

doing the wrong thing and that I think the general message that staff, both in corrective services and Justice Health, have is that a patient's consent is very, very important to have. And so I think we've heard a lot over the last few days about some areas that there needs to be some more work on to up-skill staff but I think the general, feeling is very much that I think staff don't want to do the wrong thing and they are very worried about speaking to family or lawyers without the patient's - without the patient's consent.

But my understanding of the privacy legislation is very much that you're allowed to receive information from a concerned - well, they don't even have to be concerned family, but from family and from carers and often it's invaluable information that we gain particularly with patients have major mental illness and may not have insight into their illness and collateral is often key and so we really rely on the information that family and carers have even in instances where patients may not consent to us disclosing information about their current circumstances to family. So I guess, we have more experience dealing with that - the nuance of what we're capable of doing than someone like Ms Georgiou or even the psychologist who may not have expertise dealing with those kind of - the particular parameters of the legislation."[318]

316. Dr Spencer said that correctional centre staff are definitely able to receive information from family, carers or lawyers. She said that urgent consent of an inmate to give information to a family member could be obtained. She said that the family member should telephone the "1800" helpline number. The helpline is staffed by senior mental health nurses during the day and they would contact the nursing unit manager in the centre who would be able to speak with the patient.[319]

317. Dr Spencer agreed to the concept of a policy providing for an inmate's consent to cover the 24 hour period when in a RIT cell so that family information could be obtained.[320]

Further evidence of Dr Spencer

318. Ms Alderton asked Dr Spencer about the wait times for an inmate at Kariong CC to be seen for a mental health assessment. Dr Spencer said that in September 2019, there were 23 inmates on the waitlist, of which nine were to see a psychiatrist. She said some of those would have been follow-ups and some would have been triaged based on urgency. I note that number is about a quarter of the then Kariong CC population. The mental health assessments were conducted via telehealth and Dr Spencer said it

[318] Transcript 21/10/21 T 383.35-384.6.
[319] Transcript 21/10/21 T 383.5-12.
[320] Transcript 21/10/21 T 383.25.

would be unusual for someone to be seen on the day of referral (even if a priority referral).[321]

319. Dr Spencer spoke about the fact that psychological services are provided by CSNSW whereas Justice Health does not have such a service:

> "*I think there's a - it's not necessarily just a split mode of care but I think the corrective services and Justice Health have very different sort of fundamentally - fundamental overarching principles, you know, Health psychologist is - has got a very different remit from a psychologist who's primary employed by corrective services and Health would really love to have a multi-disciplinary team like you would have in a community setting. Unfortunately, we're very limited by resources in custody. But in an ideal world, we would definitely have Health psychologists working alongside corrective services team as the current network team of mental health professionals."*[322]

320. In relation to RIT review teams, Dr Spencer was supportive of Justice Health maintaining a role. She said that CSNSW psychologists used to be involved in review teams but they are now replaced by SAPOs and could not recall the circumstances of that change.

Conclusions as to issues

321. At the commencement of the inquest hearing an issues list was distributed to parties. Some issues resolved upon the acquisition of further documents over the course of the hearing. Some issues diminished and others became emphasised.

Issue 1 and 4 - Was the management of Bailey's mental health in custody by CSNSW and Justice Health in the period leading up to his death reasonable and appropriate, including in regard to drug use, anxiety, distress and risk of self-harm, with reference to relevant policy and procedure?; and

Issue 5 - Was it necessary and appropriate for Bailey to be placed under the supervision of the RIT and in a CCTV monitored safe cell on 4 and 5 November 2019? Were the responses by CSNSW and Justice Health to Bailey's behaviour while in the safe cell appropriate and consistent with relevant policy and procedure?

322. According to Dr Eagle, Bailey had a generalised anxiety disorder, panic disorder and a severe substance use disorder (in remission in a controlled environment). Professor

[321] Transcript 21/10/21 T 388.15-30.
[322] Transcript 21/10/21 T 389.25-36.

Large opined that Bailey primarily had a severe substance abuse disorder (that was not necessarily in remission) and that his significant disturbance of conduct and emotions was consistent with a personality disorder of moderate severity, which may have been less disabling had he been able to quit using drugs. Professor Large agreed that Bailey did have anxiety but he thought it likely that it was due to his very long-standing drug use and increased trauma (including trauma experienced in prison). Dr Furst thought that Bailey likely had an anxiety disorder but agreed with Professor Large that Bailey primarily had a substance abuse disorder.

323. Without going into the intricacies of Bailey's diagnoses, it is uncontroversial that he needed help and support to deal with his situation of being in custody (bail refused) on charges which, if convicted, would result in a sentence of further imprisonment. Bailey had an inability to adjust to this situation and cope with it. As a result of these difficulties, Bailey had seen a psychologist on 3 September 2019 at Lithgow CC. He reported struggling with new charges, being back in custody and experiencing anxiety. The psychologist identified that Bailey should attend psychological counselling on a weekly basis, presumably to gain some assistance in emotional regulation and processing his predicament so that he could adjust to his situation and deal with some of the factors giving rise to it.

324. The psychologist ranked Bailey as a "P2" priority which meant, according to CSNSW policy, that he should be seen within 12 weeks. Bailey was seen nine weeks later and the result of that attendance was being placed on the RIT status. The fact that Bailey was not seen earlier may be due to him been transferred to a privately managed CC and then to Kariong CC. The delay of up to 12 weeks, to meet a recommendation for weekly counselling for a young inmate to adjust and learn to cope with his environment and situation, is likely too long. However, he was assessed not to be in such crisis that he needed to be seen within three days as the "P1" criteria requires.

325. On that basis, there was no breach of policy. However, Bailey still did not receive the psychological support he needed after he was placed in the assessment cell on 4 November 2019. He did not receive any mental health support on 5 November 2019 though RN Georgiou attended to his physical wellbeing. I agree with Counsel Assisting's appraisal that RN Georgiou was a dedicated Justice Health Nurse, attempting to fulfil an overwhelming role being the only nurse rostered at Kariong on 5 November 2019. As said by Counsel Assisting, RN Georgiou's evidence demonstrates the tremendous pressure faced by nursing staff providing care in a correctional centre.

326. Dr Phillip Snoyman, Director of Statewide Services CSNSW, provided a statement at the request of those assisting me which addressed the role of psychologists in the CSNSW system. His statement sets out that psychologists work in geographic clusters and the services provided include assessments, consultations, provision of reports about offenders, liaison with offender management and others in both custodial and community corrections. Mr Snoyman wrote that the psychologist service includes the provision of services to vulnerable inmates, inmates with specific needs and more intensive series for offenders who present with marked difficulties coping with or adjusting to custody. They deliver programs both in the community and custodial settings. Whilst his statement addressed the breadth of the service, it was not required to address the timeliness or resource availability for the provision of those services.

327. At the time Bailey was in Kariong CC, for her part Ms Hyde made it clear that there was no time or resource availability to provide counselling to an inmate on a weekly basis. There was no evidence about Ms Hyde's waitlist, but Bailey was seen by her within a week of his arrival in Kariong CC. The Justice Health mental health waitlist had nearly a quarter of the Kariong CC population on it and although there was no indication as to the delays involved in such a referral, it appears that it was at least a week.

328. On 12 September 2019 at Parklea CC, Bailey was distressed after an appearance in court and he saw a mental health nurse on 13 September 2019. Dr Eagle said that attendance warranted a medication review and she noted that Bailey never received a comprehensive mental health assessment as anticipated. I also note that on 22 September 2019 Bailey saw a mental health nurse but it is unclear whether it was for a comprehensive mental health assessment.

329. It is concerning that there was no mental health nurse on site at Kariong CC and that the telehealth service involved a delay so that an inmate such as Bailey could not be urgently assessed. In the community setting, hospital EDs, acute mental health teams and community mental health teams are available on a 24/7 basis. In the custodial setting, the ROAMS system and the Mental Health Helpline seeks to provide similar access. The reasons that such access does not manifest in adequate on-the-ground services is likely multifactorial, even down to the resources and whether a single nurse on the day literally has sufficient time to make a referral. The resourcing of adequate staff to cater for the needs of a population with probably higher and more intensive needs than the general community was not a matter for this inquest, but it does go without saying that unless a correctional facility is adequately staffed and resourced to

provide services, the provision of those services is likely to be inadequate. That Bailey was not given access to the Justice Health Mental Health Helpline on 5 November 2019 was an oversight by RN Georgiou.

330. I accept Dr Eagle's opinion that Ms Hyde appropriately identified that Bailey had an overall increased risk of suicide and his risk factors warranted mental health involvement and further comprehensive clinical review (as well as liaising with his mother).[323] I accept Ms Mahony's submission that there should be no criticism of Ms Hyde for placing Bailey on a RIT.

331. Ms Hyde had consulted with RN Georgiou about Bailey and informed her that she was raising a Mandatory Notification. Ideally, RN Georgiou would have then completed the necessary notifications and commenced a referral to Bailey for a mental health assessment (if not on the day, then certainly on 5 November 2019, particularly at the conclusion of the RIT Review Management Plan). However, given that the next two to three hours of her time were absorbed with attending to Bailey, and she then had to provide services to the other inmate population, it is understandable that she did not do so. RN Georgiou sent an email at 12:34am on 6 November 2019 to the next nurse on duty, regarding numerous inmates including Bailey. In relation to Bailey, RN Georgiou wrote, "*he needs transfer to an appropriate centre. I did not have the chance to complete the transfer out request or email…about an appointment, could you please follow up today*".[324]

332. Mr de Mars referred to RN Georgiou's evidence that Bailey could not be transferred from Kariong CC to another correctional centre if he was on a RIT. RN Georgiou was incorrect about that.

333. I note Mr de Mars' submission that Bailey should not have been transferred to Kariong CC which is addressed below. Mr de Mars submits that a further basis to find that Kariong CC was inappropriate for Bailey was that according to Mr Cargill, there was a local practice that an observation cell at Kariong CC should not be used for any period longer than 24 hours as the annexed courtyard was closed due to having hanging points. Given the resources at Kariong CC, such an inmate could also not have access to that exercise in the general yard. Accordingly, it was submitted by Mr de Mars, it was not possible for an inmate housed in a Kariong CC assessment cell to receive their required two hours of exercise pursuant to cl. 53 of the Regulation. This

[323] Ex 1, Vol 5, Tab 74, p.22, [143.2.1].
[324] Ex 13.

submission overlooks Ms Dolling's evidence that in her experience, 90%[325] of the time if an inmate was placed on a RIT at Kariong CC, it effectively equalled an assessment cell and it was quite a common practice to allow inmates access during the day to the yard.[326]

334. Clause 53(1) of the Regulation mandates that an inmate should receive two hours of exercise in the open air. However, under cl. 53(3) an inmate's entitlement to exercise is "*subject to the practical limitations that may from time to time arise in connection with the administration of the correctional centre concerned*".

335. The only explanation as to why the RIT review management plan did not include a diversionary activity consistent with Bailey's right to two hours exercise in the open air is that Mr Dolling said it was the assessment cell or nothing. Given the limited open air facilities available that day at Kariong CC, there may have been practical limitations to enabling Bailey having access to the yard on his own and/or on a supervised basis. However, Mr Dolling's evidence in that regard was somewhat disingenuous when he tried to say that the option was a matter for the RIT review team,[327] and then on the other hand said *"[t]he layout of Kariong, the way it was set up; I would not think that Bailey would have been given access to the exercise yards*".[328]

336. If an inmate is denied access to exercise due to the way a correctional centre is set up, then it is arguable that no inmate should be in an assessment cell under the RIT procedure at that centre. Obviously, if the risk of harm is so urgent and a cell is required to contain the inmate (so as to prevent access to the means to self-harm), such containment should occur. However, in my view that should only occur if the inmate is either transferred within 24 hours to a more appropriate centre where cl. 53 can be complied with, or placed on a management plan under which access to two hours of exercise is mandated and appropriate resources are provided for the necessary monitoring or supervision required during the continuation of an assessment cell placement.

337. Mr de Mars also submitted that there has been a breach of cl. 164 of the Regulation because:

> *"(1) An inmate must not -*
> *…*

[325] Transcript 19/10/21 T130.21.
[326] Transcript 19/10/21 T132.14.
[327] Transcript 18/10/21 T15.3-10.
[328] Transcript 18/10/21 T15.30-32.

(c) be subjected to any other punishment or treatment that may reasonably be expected to adversely affect the inmate's physical or mental health".

338. John Brown made it clear in his evidence and Bailey made it extremely clear that experiencing an assessment cell is a highly unpleasant and undesirable experience such that inmates deem it to be a punishment. Whilst segregation and protective order placements are legislated in the *Crimes (Administration of Sentence) Act 1999*, RIT assessment cell placements are not. This seemingly gives more rights to the segregated inmate than the inmate who is placed in an assessment cell and denied diversionary activities such as human contact or exercise under a RIT management plan. At least an inmate who is subject to a segregation order has a process whereby the decision can be reviewed - there is no such process for an inmate involved in a RIT review decision.

339. As Dr Eagle highlighted in her report and evidence, there is no legislative framework for the use of assessment cells. Further, there is not only a prohibition on secluding a person at risk in the NSW Health setting, there is a legislative framework for the hospitalisation and treatment of those persons under the *Mental Health Act 2007*.

340. Ms Lewer's submissions spoke to the recommendations that have been put forward on behalf of David and Melissa Mackander that CSNSW's continued use of RIT assessment cells should be properly administered, managed and audited so that the correct balance of inmate protection, CSNSW's duty of care and humane treatment is achieved. Those proposed recommendations are addressed below.

341. Bailey's mental health was adversely affected by his assessment cell placement and the continuation of this confinement on 5 November 2019. That is borne out in Dr Eagle's evidence that Bailey's level of distress, anxiety and panic significantly increased (from that identified by Ms Hyde prior to raising the Mandatory Notification). Though there may have been a part in which Bailey was manipulative and maladaptive, I am confident that he was experiencing distress, anxiety and panic attacks on both 4 and 5 November 2019 as demonstrated audibly over the CICs, visually on the CCTV footage, verbally over the telephone to Tracy on the first day and in person to John Brown on both days. Although Bailey complained of chest pain on 5 November 2019 prior to seeing the nurse, and then told her his chest pain was fine and that he just wanted to get out of the cell, that does not mean that he was pretending to have chest pain. Rather, it is likely that he was aware that the chest pain was related to him being in the observation cell.

342. There were at times some demeaning and somewhat punitive comments made to Bailey by correctional officers over the two days that he repeatedly used the CIC system while in the assessment cell. The treatment he received fell short of amounting to punishment, although I am sure Bailey experienced it in that way. It was not one singular instance, but rather the general treatment of Bailey, that adversely affected Bailey's mental health.

343. It seemed that for RN Georgiou, any concerns for Bailey being at risk of self-harm were displaced by RN Georgiou's concern to get Bailey medically or physically through the day and transferred out of Kariong CC. As for the senior correctional officers Mr Lloyd and Mr Dolling, if there was any concern for Bailey's safety it was overridden by a correctional attitude and style for Bailey to develop the adult inmate coping skills that he did not possess. He did not possess them due to the issues discussed by the psychiatrists, but he also did not possess them because he was only 20 years old with teenage years marked by a serious substance use disorder. He was the second youngest inmate at Kariong CC.

344. Ms Mahony submits that "*CSNSW firmly states that it was necessary to place Mr Mackander under supervision of the RIT and in a camera cell on 4 and 5 November 2019*". That CSNSW takes such a position is consistent with Ms Lewer's submission that an assessment cell is a blunt tool used by CSNSW to protect an inmate from self-harm. These findings, particularly in relation to the RIT review process, indicate that I do not share CSNSW's position in that regard. As I note above, however, I do not criticise Ms Hyde's decision to place Bailey on a RIT.

345. To continue with Ms Lewer's analogy, the CSNSW management of Bailey on 5 November 2019 was akin to forcing a square peg fit into a round hole. Bailey's maladaptive coping strategies to being in a prison generally and in the assessment cell specifically were not understood and appropriately responded to and no-one appeared to look into the tool kit to see what else was at their disposal.

346. In that regard, Dr Spencer spoke plainly and wisely when she said:

> "*Often it isn't medical treatments that these patients who are very distressed need; they just need someone who's going to listen and who's going to treat them like a human being, or more like a family member. And you don't need really a lot of mental health training to know that some of the things that were said to Bailey were not going to make him feel fantastic; and that he was pretty worried…. This is just about treating people humanely, and thinking about how you can*

individually make a difference to how someone's circumstances are then and there. And there were things that could have potentially been done, like giving him access to the yard, and potentially putting him in a camera cell overnight. But I think the team didn't know that it was available to them; but with hindsight was available, and would have perhaps made a difference to his distress…"[329]

347. I agree with Mr de Mars that I should accept Dr Eagle's view of the use of assessment cells, and in particular her view that:

> *"… The use of safe cells in managing suicidal behaviour is counter therapeutic, disempowering and distressing for prisoners, and adds no clinical value, but likely heightens the individual's risk of self-harm or desperate behaviours. The use of a safe cell, or assessment cell in this case, was observed to significantly increase Mr Mackander's distress and was associated with an escalation in apparent desperate behaviours to be released from the cell. Persons with suicidal behaviours or in acute distress, should have access to a comprehensive mental health assessment and services, and if at risk should be transferred to and managed in acute mental health facilities, such as in other jurisdictions in Australia...."*[330]

348. Though Dr Furst disagreed that assessment cells should not be used and he sought to explain that the assessment cell provides an opportunity for an inmate to achieve some equilibrium, he mainly spoke of the facilities in relation to such cells in the Acute Mental Health Management Units. He did agree that Bailey was distressed in the observation cell and that a referral to a mental health nurse should have been expedited.

349. For the reasons already articulated, I find that although it was necessary and appropriate for Bailey to be placed under the supervision of the RIT, it was not necessary and appropriate for him to be placed and kept in the observation cell. I do not consider that the RIT review process was appropriate or adequate.

<u>Issue 2</u> - Why did CSNSW transfer Bailey between various correctional centres from 16 July 2019 to 5 November 2019? Did this have any adverse impact on his mental health? Are there policies or procedures in place to minimise inmate transfers for vulnerable prisoners?

350. There is no evidence to suggest that the transfers were inappropriate or had any particular adverse impact on Bailey's mental health. The inquest did not inquire into

[329] Transcript 21/10/21 T396-397.
[330] Ex 1, Vol 5, Tab 74, excerpt of [143.1.2].

policies relating to minimising inmate transfers of vulnerable prisoners (other than as set out below).

351. Mr de Mars submits that Bailey should not have been placed in Kariong CC, adopting RN Georgiou's evidence in that regard. Mr Murrell said that Bailey's placement was positional in that he was due to appear in Newcastle Local Court in the near future. On that basis, Bailey must have been required to appear in person rather than AVL, although that has not been inquired into by the inquest.

352. Mr de Mars submits that there should have been a system in place that provided an appropriate check on Bailey's suitability for his transfer to Kariong CC. Mr de Mars' submission relies on the Justice Health Transfer In and Out Form ("TIOF") completed for Bailey's transfer from the privately managed CC to Kariong CC.[331] The Justice Health Policy 1.395, "Transfer and Transport of Patients"[332] ("Policy 1.395"), in particular at section 3.1.9, identifies Kariong CC as an isolated site. As such, it requires CSNSW to provide a list of transferees to the local Nurse Unit Manager ("NUM") on the **Inmates for Transfer to a Remote/Isolated Site Form**. The NUM must ensure that a review of the patient's health and other relevant records is undertaken and the **Remote Site Assessment Criteria Checklist** is completed. The NUM is required to interview each patient and detail any reasons for exclusion of transfer to the proposed isolated site. If Justice Health staff located in remote sites are concerned about the appropriateness of a patient transfer to their site, they are to contact their appropriate delegate in regard to the suitability of the destination. I note that this last requirement does not apply to isolated sites.

353. The TIOF's section "Is the destination suitable?" refers to both remote and isolated sites by name, but it does not include one site - and that site is Kariong CC. If that is a typographical mistake in the form it should be corrected as it may result in, as appears to have occurred in this case, a lack of regard to Policy 1.395. It does not appear that Bailey was included in any **Inmates for Transfer to a Remote/Isolated Site form** and he was apparently not interviewed as required by Policy 1.395. Despite these failings, the TIOF's section asking "Is the destination suitable?" has been ticked.

354. I note that the TIOF for Bailey's transfer to Kariong CC did not include any comments, but in the section asking "Is the patient suitable for transfer?", a history of "*Hep C/ Anxiety*" and "*ATSI*" is written. The three previous TIOFs have comments recorded in

[331] Ex 1, Vol 3, Tab 43, p. 36.
[332] Ex 23.

that section as follows: 10 September 2019: [333] "*Alerts: … SH [Self Harm]*"; 9 August 2019: Aboriginal, Hx [history] Self Harm, current mental illness[334]; and 28/7/19: "*ATSI MH [Mental Health] issues*". All documents except the TIOF dated 9 August 2019 referred to the existence of a "*current HPNF*" in the section asking "*Is the transport suitable?".*

355. The evidence is insufficient to establish that, had the Policy 1.395 been adhered to, Bailey would not have been transferred to Kariong CC. The evidence is insufficient to make a finding that Bailey should not have been transferred, although obviously Kariong CC was inappropriate (due to the events that occurred in relation to the RIT, and in particular the lack of mental health support and the mismanagement of the RIT management plan, together with the adoption of a certain management style of correctional officers).

356. Dr Spencer indicated that at the relevant time, Kariong CC accommodated generally young Aboriginal men and on that basis she thought that Kariong CC was probably a good placement for Bailey. She indicated that his mental health needs could be met even through the telehealth system. Given the number of people to be seen on that list, whether it would have met Bailey's need for a mental health review as identified prior to his transfer to Kariong CC may be arguable. Bailey's family lived in the area and when Bailey spoke to his parents before going on the RIT he seemed quite happy to be at Kariong CC.

<u>Issue 3</u> - Was the response by CSNSW to Tracy Mackander's attempts to contact CSNSW about Bailey's mental health in the days leading up to his death reasonable and appropriate?

357. I find that Ms Hyde should have accepted Tracy's call on 4 November 2019 and I do not accept that she lacked the skills to negotiate the issue of receiving information from Tracy and not being able to tell her information without Bailey's consent. There was no impediment to Ms Hyde obtaining Bailey's consent in the afternoon and calling Tracy back.

358. Likewise, with reference to the evidence set out above at [310] to [317], there was no good reason for a telephone call from Tracy not to have been accepted at Kariong CC on 5 November 2019.

[333] Ex 1, Vol 3, Tab 43, p. 38.
[334] Ex 1, Vol 3, Tab 43, p. 39.

359. The fact that the RIT Review Management Plan apparently did not consider that Bailey could make a telephone call to Tracy on 5 November 2019, as had occurred the previous day under the ISP, was a lost opportunity for them to consider the input Tracy could have in Bailey's management.

<u>Issue 6</u> - Did Bailey ingest razor blades, batteries or any other foreign bodies prior to his death? If so, in what circumstances?

360. Counsel Assisting referred in her submissions to an expert radiological report from Dr Raleigh. Dr Raleigh at the request of those assisting me reviewed Bailey's medical records and the autopsy report in regard to whether the CT trauma scan performed on 5 November 2019 had shown foreign metallic bodies in Bailey abdomen; and whether there were any differences between that imaging and the subsequent post-mortem scan. Dr Raleigh was also asked to compare the items identified as having been located at autopsy with that imaging. In his report, he says that there were metallic foreign bodies in Bailey's abdomen. The rocks located in Bailey's abdomen at autopsy are likely those that were considered to be the metallic foreign bodies identified on the CT trauma scan. The plastic bag and polystyrene cup fragments would not be identifiable on such a scan. Accordingly, I accept Counsel Assisting submission, and it is not controversial, that there are no inconsistencies between the CT scans and the autopsy findings. Bailey did not ingest any batteries or razor blades on 5 November 2019.

361. Bailey said that he had done so in order to attend the hospital. At some unknown time, Bailey did ingest small rocks, pieces of plastic, polysterene and paper. The CCTV footage of the assessment does show Bailey at times, consuming something consistent with a polystyrene cup, However, though he was under observation, there is no evidence that this was noticed.

<u>Issue 7</u> - Was the medical escort of Bailey by CSNSW escort officers Mr Slingsby and Mr Uerata to Gosford Hospital on 4 and 5 November 2019 and following discharge, conducted appropriately and in compliance with CSNSW policy?

362. I find that the escort of Bailey on both 4 and 5 November 2019 did comply with CSNSW policy. Though Mr Cargill and Mr Dolling said that Mr Slingsby should have had physical hold of Bailey due to the escort risk assessment, neither the escort assessment nor the s. 24 order suggested that such a hold was required.

363. Mr Slingsby misjudged Bailey's demeanor and failed to understand that concerns for Bailey's impulsivity were not restricted to inside the hospital setting. Given that the ambulance ramp was not a site of public access, there was no need to be concerned about exercising a prisoner hold in public. Mr Slingsby was on notice that Bailey was impulsive and he knew that he was in an assessment cell for suicidality. Mr Slingsby did not know that there was a drop behind the wall in the ambulance bay, so he would have had no reason to consider that it would be an object or means to self-harm. He was mindful of Bailey inside the hospital grabbing something to hurt himself. The escort assessment did not suggest that Bailey was an escape risk. Mr Slingsby said he would hold an inmate if they were aggressive and Bailey was absolutely not aggressive. Even though Mr Slingsby was aware that the moment an inmate is about to enter the van is a moment of higher risk of agitation, he did not take hold of Bailey as he did not want to add to that stress. In hindsight, that was an error of judgement.

364. Mr Reitano made numerous submissions in relation to the powers of correctional officers under legislation. I do not accept that the holding of an inmate's handcuffs by an escort officer is an act of force. In any event, Mr Slingsby did not say he did not hold onto Bailey's handcuffs because he did not want to commit an assault, and nor could he, given that he held onto Bailey's handcuffs entering the Hospital.

365. The van should not have been parked so close to the unsecured perimeter wall as it was not the closest parking bay to the ED entrance of the Hospital; however it was the bay that the Hospital had advised CSNSW to use for parking.

<u>Issue 8</u> - What information was conveyed and what documentation was provided by CSNSW officers to Gosford Hospital regarding Bailey at his admission on 5 November 2019? Was this sufficient in the circumstances and in compliance with relevant policy and procedure?

366. The appropriate documentation was provided and this was ultimately not an issue in the inquest.

367. However, Mr de Mars submits that there should be a policy requiring documentation of a patient's history and recent presentation to be provided to clinicians at the hospital. Since this incident, a Memorandum of Understanding between NSW Health and CSNSW agreed in May 2021 has been introduced to address information sharing on arrival at a hospital as a standard practice.

<u>Issue 9</u> - Was the medical care, treatment, discharge and proposed management of

Bailey by Dr Cameron on 5 November 2019 (including the use of a metal detector) reasonable and appropriate, with reference to relevant policy or procedure?

368. I address Dr Cameron's care of Bailey on 5 November 2019 above at [290] to [291]. I accept Dr Cameron's concession that it was not appropriate to use a metal detector in the manner he did and to not proceed with an x-ray on 5 November 2019; however, I also accept that if he had conducted an x-ray, that would not have altered his management plan for Bailey.

369. Mr de Mars submits that there was evidence from expert Professor Holdgate that Dr Cameron should have conducted a mental health assessment when learning that Bailey presented for swallowing objects. There were competing views about this and neither Dr Holdgate nor Dr Cameron was required to give evidence. I accept Professor Large's evidence indicated that neither of Bailey's presentations warranted such an examination in an ED hospital setting.

<u>Issue 10</u> - What led Bailey to escape custody and jump over the carpark wall at Gosford Hospital?; and

<u>Issue 11</u> - Was Bailey aware that the other side of the carpark wall was a significant height from the ground?

370. Ms Mahony submits that it is open to find that Bailey had in his mind an intention to be transported to hospital for the purpose of absconding. I accept that Bailey orchestrated going to hospital as he did not swallow the objects he claimed to have swallowed. He likely faked feeling pain in his stomach, although he may have had some discomfort given the items including rocks and polystyrene located at autopsy. Bailey had told John Brown he would fake an illness the previous day to get out of the cell, which was likely his motivation to attend hospital.

371. Any plan for escape was completely futile and unrealistic given that Bailey was shackled at hand and foot. That Bailey attempted to escape points to how impulsive his act was. Bailey knew that he would be shackled, because he had been on his first attendance at hospital on 4 November 2019. Bailey had every reason to think that the lack of opportunity afforded to him by the way the escort was conducted the previous day would be replicated on 5 November 2019. Any notions of escape were likely abandoned when they were replaced with the need to simply get out of the assessment cell or not be returned to it.

372. I have no doubt that Bailey did not realise that there was an eight metre drop to the ground from the top of the wall. The fact that Mr Slingsby chased Bailey by jumping up onto, rather than over, the wall saved him from also falling to his death.

373. Bailey was vulnerable and had personality frailties as advanced by both Dr Eagle and Professor Large. Bailey experienced anxiety and distress which was seriously exacerbated when he was in the assessment cell - a cell with 24/7 lighting and no access to open air. Despite demonstrating settled and calm behaviour overnight from 4 to 5 November 2019 so that he might be discharged from the cell, Bailey was not reviewed and discharged at 8am as he had been told would occur. When Bailey did meet with the RIT review team, the decision was made to keep him in the cell with increased restrictions that were unjustifiably imposed under the management plan.

374. Bailey was told that if he continued being distressed in the cell he would be in there for much longer. He received no psychological or mental health support and was subjected to a correctional management style that resulted in frustration and a lack of understanding as to how to deal with Bailey's escalating deterioration. Bailey was discharged from the Hospital so quickly, to be returned to the cell, that he only had a short period of respite. All of these experiences likely informed an extremely impulsive and utterly tragic move when Bailey saw that Mr Slingsby was distracted opening the van door.

375. The height of the perimeter wall was such that it could be vaulted so easily by a person even in shackles, and the location gave no sense that the wall was above a deathly drop. Those factors contributed to Bailey's impulsive act.

<u>Issue 12</u> - Was the CSNSW response to Bailey's death, including the findings of the investigation report dated 6 November 2020, adequate?

376. The CSNSW investigation is referred to above at [300] to [309]. As I note at [306], Mr Hovey gave evidence that if CSNSW investigators were conducting investigation now, they would now delve further into systemic processes such as the RIT process.

377. I find that the CSNSW investigation identified the central circumstances relating to Bailey's death. The Investigation engaged in a thorough collection and transcribing of the CICs which are relevant to Bailey's manner of death. Due to an investigator experiencing trauma from having done, the investigation became delayed until a replacement investigator was available. During an earlier stage of the investigation relating to cause of Bailey's death, that investigator was unable to continue due to

associated trauma. That incident reports were relied on rather than statements of officers as witnesses has been noted by Mr Hovey who expressed that now an investigation would or should involve the taking of statements from relevant persons. Arising out of the CIC records, the investigation adequately and appropriately addressed the need for correctional officers to have adequate mental health training.

Issue 13 - Are there any recommendations necessary or desirable in relation to any matter connected with Bailey's death?

378. According to submissions made by Mr Rooney, as at **22 June 2020**, the Kariong CC became known as Kariong Transit and Intake Centre ("TIC"). The centre sees inmates transiting in and out seven days per week. The expectation now is that inmates do not remain at Kariong TIC for longer than 24 hours. It is unknown whether this expectation means that inmates would not be placed on a RIT and in an assessment cell at Kariong TIC.

379. Counsel assisting put forward eight recommendations (1-8) to CSNSW and six recommendations (9-14) to Justice Health and two recommendations (15-16) to CSNSW and Justice Health jointly. Those recommendations were added to by Bailey's parents. Justice Health and CSNSW then responded to them. I extend my appreciation to Ms Mahony who represents CSNSW and Mr Rooney on behalf of Justice Health for their diligence and commitment to give due consideration to the many matters raised in the recommendations. I was greatly assisted by their approach and structure of their documents.

380. I set out below the recommendations I make in this inquest.

Recommendations

Recommendations to CSNSW

Recommendation CS 1

381. The first recommendation put forward by counsel assisting is that a psychologist be a required member of the RIT review team. The amendment sought by Mr de Mars was that in the event that an onsite psychologist is not available at the time of the review, then a psychologist located at another centre participate via telehealth with the assistance of an on-site SAPO, and that there be a list of on-call psychologists for this purpose.

382. CSNSW oppose the recommendation for the following reasons:

(i) Lack of resources: There are insufficient psychologists employed by CSNSW and the use of psychologists to fulfil this service would impact upon the ability to provide services to other inmates. Further, SAPOs are an appropriate substitute to a psychologist for RIT reviews.

(ii) The use of telehealth is inappropriate: The psychologist that would need to meet with the inmate would have insufficient information and be unable to draw on local resources to enquire about the background of the inmate. It would be improper for a psychologist to provide a professional view without adequate contact with the inmate.

(iii) Delay in review: Mandating that a psychologist be a member of the RIT may cause delay as the psychologist may not be able to prioritise attendance in a meeting with other priorities on the day.

(iv) No on call list: Psychologists employed by CSNSW do not work after hours or on call.

383. Considering the compelling evidence Dr Eagle gave in relation to the practice of isolating people at risk of suicide, it is simply not possible to reconcile the CSNSW submission that a SAPO is an appropriate substitute for a psychologist in making such a decision in the RIT review meeting.

384. Regrettably, I accept that psychologists are a highly stretched resource in CSNSW correctional centres, such that though they apparently once did sit on RIT review teams, a need to preserve their services for other priorities resulted in CSNSW engaging SAPOs to occupy their once held role in the RIT review meetings. Also, Justice Health does not employ psychologists, which adds to the dearth of psychological resources to assist inmates in NSW correctional centres. CSNSW does not refer to any prospects of additional funding to improve psychological services.

385. I acknowledge that the manner in which public funds are to be allocated is appropriately left to members of the executive government and as the advancement of the recommendation is dependent upon such funding, I am unable to advance it any terms other than as follows:

> Recommendation CS 1
>
> That CSNSW amend the “Management of Inmates at Risk of Self-Harm or Suicide” policy to require a co-ordinator of a RIT review meeting to seek that a

psychologist be a member of the RIT and in the event that the psychologist is unable to participate in the review meeting, provide an opportunity for the SAPO and/or Justice Health member of the team to consult with the centre's psychologist or an off-site mental health service provider, prior to any determination of the RIT review team.

Recommendation CS 2

386. The second recommendation proposed by counsel assisting related to amending policy and procedure to reflect that it is the responsibility of the RIT coordinator to compile and distribute a folder to the RIT prior to the convening of a RIT review. CSNSW supports this recommendation but due to the health privacy arrangements with Justice Health, CSNSW opposes including Justice Health documents in the folder (which was an additional proposed item in the list of documents). For those reasons, I decline to include a requirement that the folder contain Justice Health documents.

387. Accordingly, the recommendation has been amended and is made in the following terms:

> Recommendation CS 2 (a)
>
> That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to indicate that the RIT coordinator is required to compile and distribute a folder of specified documents to the RIT members prior to the RIT review meeting in sufficient time so that those members are informed of the matters contained therein. The documents are to include:
>
> i. the Part 1 Mandatory Notification;
> ii. prior Mandatory Notifications, ISPs and RIT plans;
> iii. recent OIMS case notes with regard to the mental health of the inmate;
> iv. any observations of the inmate in a cell made while on an ISP or a RIT; and
> v. current OIMS alerts in relation to the inmate.

388. Counsel assisting's recommendation 3.f, with amendments proposed by Mr de Mars, is supported by CSNSW. I make a recommendation in similar terms as follows:

> Recommendation CS 2 (b)
>
> That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to provide that any ISP and RIT Management Plan must include written reasons as to the following:

i. the decision to place the inmate on the ISP or the RIT;

ii. the cell placement, including reasons why a less restrictive placement option, if available, is not suitable; and

iii. if a less restrictive placement option is unavailable at the time, why that option is unavailable and when, if ever, it will be available.

389. In addition, CSNSW opposed recommendation 3.g as put forward by Ms Lewer on behalf of David Mackander (which provided that a RIT plan should specify who can be contacted if the RIT co-ordinator is unavailable before the next review). CSNSW opposed that for a number of reasons, the first being that it would not be known who the RIT co-ordinator will be. I do not accept that explanation as I expect that in most cases a 24 hour roster of who the senior correctional officers are that are in charge would be known. The second reason put forward by CSNSW was that the evidence demonstrated it is the Justice Health nurse or the psychologist who can and should be contacted. I do not accept that the recommendation contradicts that process.

390. The evidence demonstrates the need for a singular manager to be identified and to be responsible for the management of the inmate and liaise with any staff member who has communications with a third party. Accordingly, the recommendation is desirable so that there is a single person at a point in time to take responsibility for the management of an inmate on an ISP or RIT plan.

391. The recommendation therefore is as follows:

Recommendation CS 2 (c)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to provide the following:

i. That any ISP and RIT management plan identify in writing the names of the person/s and/or designation of office who will be responsible for the management of the inmate on the relevant shifts until the next RIT review; and

ii. that this information is provided to the inmate.

Recommendation CS 3

392. CSNSW supported counsel assisting's proposed recommendations 3.b-c (regarding opportunities to make telephone calls for an inmate who is placed on a Mandatory Notification and subject to a RIT). However, CSNSW opposed a proposed amendment to the recommendation to allow unlimited telephone calls to the approved support

person, on the basis of resourcing and security concerns. I am of the view that it would be sufficient for an inmate to have an initiating phone call, another call at each 24 hour mark in the event that the RIT is extended, and a final phone call when the inmate is discharged from the ISP or RIT management plan.

393. The policy should clarify that any additional telephone calls to an approved support person are to be at the discretion of the officer managing the inmate.

394. The policy should make it clear that these telephone calls are not a substitute for any telephone calls for the purpose of human contact or interaction as set out in the ISP or RIT management plan or discharge summary.

395. I make the recommendation as below:

Recommendation CS 3 (a)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to provide the following:

i. That an inmate placed on an ISP is to be provided the opportunity to have telephone contact with an approved support person (approved by the governor or delegate). Such telephone contact by the inmate is to be facilitated as soon as possible - preferably within two hours - of the inmate being placed on an ISP.

ii. That a phone call from an inmate to an approved support person be facilitated at the establishment of a RIT Management Plan and upon each 24 hour extension of such plan.

iii That a phone call from an inmate to an approved support person be facilitated at the discharge from an ISP or upon the establishment of a RIT discharge plan.

iv The policy should clarify that any additional telephone calls to an approved support person are to be at the discretion of the officer managing the inmate.

v. The policy should make it clear that these telephone calls are not a substitute for any telephone calls for the purpose of human contact or interaction as set out in the ISP or RIT management plan or discharge summary.

396. Further, I make the following recommendation:

Recommendation CS 3 (b)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to include that as soon as practicable following a Mandatory Notification, the managing officer is to:

i. Inform the inmate of the decision and the reasons for the MNF and the ISP components.

ii. Inform the inmate that they are entitled to have telephone contact with an approved support person. If the inmate wishes to do so, they are to provide the name and phone number of that person and once approved by the governor or delegate, a phone call by the inmate to that approved support person is to be facilitated as soon as possible (this should occur within hours of being placed on a ISP or RIT Management Plan). If the inmate does not wish to nominate a person, that should be recorded in writing.

iii. Inform the inmate that their ISP or RIT status will be subject to review within 24 hours and that they will attend the meeting of the review team to discuss their level of risk of harm and any protective factors and safeguards that can be put in place so that they could be discharged from the ISP or RIT.

iv. Inform the inmate that they can now, or at any stage whilst on the ISP or RIT, provide written consent for CSNSW staff to communicate with specified third party(ies) for the duration of or any specified part of the ISP or RIT, with that consent to indicate the parameters, if any, of information to be provided. Further, they are to inform the inmate that this will be documented appropriately in OIMS and retained with the inmate's RIT documentation in the event that it is useful or necessary for the management and support of the inmate on the ISP or the RIT.

v. Inform the inmate that they may withdraw their consent in writing at any time and, that where there is a withdrawal of consent, that will be documented in OIMS and retained with the inmate's ISP or RIT documentation.

vi. Provide an opportunity for the inmate to provide such consent for the duration of, or a specified part of, the ISP or RIT.

vii. Request the inmate to sign an acknowledgement that the above has been explained to them and that they understand the process. In the event that an inmate does not wish to sign, the officer should record this fact and any reasons expressed by the inmate as to why they do not

wish to sign.

viii. Complete the appropriate OIMS documentation (with respect to the above) and retain the consent documents.

ix. Notify Justice Health that an inmate is on an ISP or RIT (see also, Joint Recommendation CS/JH 3).

397. Counsel assisting's (fourth) recommendation is supported by CSNSW subject to submissions which I have taken into account. I recommend as follows:

Recommendation CS 3 (c)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to require the following:

i. each RIT review member is to sign an acknowledgement of completion of the necessary training to undertake the role;

ii. the co-ordinator is to record the time of the commencement and conclusion of the RIT review meeting;

iii. the co-ordinator is to record the time at which the inmate was in attendance at the RIT review meeting; and

iv. the completion of all sections of the forms is to be carried out with the use of the assessment guideline documents.

Recommendation CS 4

398. Further, I make the following recommendation:

Recommendation CS 4

That CSNSW amend the following forms: Part 1 Mandatory Notification Form, Part 2 Immediate Support Plan, and Part 3 Risk Intervention Team (RIT) Management Plan, to incorporate the following (including to facilitate the changed policy set out in Recommendations CS 2 and CS 3):

i. the time at which the inmate is placed in the RIT assessment cell;

ii. the time at which the ISP is commenced and the time/s at which it is completed and/or amended;

iii. an acknowledgement to be signed by each RIT review member of completion of the necessary training to undertake the role;

iv. the times at which those adopting the contents of the form signed, and the legible names of the signator/s; and

v. the time/s at which the inmate attends and departs a RIT review meeting.

Recommendation CS 5

399. Ms Lewer has advanced numerous recommendations, some of which are opposed by CSNSW and some of which have been accepted subject to modification.[335]

400. Ms Lewer puts forward a recommendation enabling a support person to accompany the inmate via remote technology when the inmate appears in the RIT review meeting. This recommendation is designed to provide some safeguard, advocacy and support for an inmate similar to that provided to a patient in a mental health setting where their case is being reviewed by the mental health tribunal.

401. CSNSW opposes the recommendation in its current form and raises a number of obstacles that require addressing before the making of any recommendation of this kind. It may be that the correctional setting means it is not a possibility, but a recommendation that CSNSW investigate whether such a process can be implemented is desirable.

402. Accordingly, I make the recommendation as follows:

> Recommendation CS 5
>
> That CSNSW investigate the implementation of a procedural safeguard enabling an approved third party to accompany and assist an inmate when they attend a RIT review meeting, on the basis that the third party would attend by remote facility such as web-conferencing.

Recommendation CS 6

403. Ms Lewer also puts forward a recommendation that CSNSW compile a list of First Nations elders and First Nations organisations, being those who are able to provide assistance and support to First Nations inmates subject to an ISP or RIT. She then put forward an extension of this recommendation that such a list be provided to any First Nations inmate if they are struggling to cope (and that CSNSW should facilitate, as is reasonably practicable, telephone contact if requested by an inmate) .

404. CSNSW agrees to explore whether such a recommendation can be implemented in relation to the ISP or RIT issue, but points out that extending it does not arise from the

[335] The numbers of these recommendations are different to those numbers applied to in the recommendations circulated amongst parties.

evidence of the inquest. Whilst that is the case, if such a resource exists for inmates on an ISP or RIT, it may prevent a First Nations inmate from escalating so that an ISP or RIT is required. If the list is available, access to it should not be restricted.

405. Accordingly, the recommendation is as follows:

> Recommendation CS 6
>
> That CSNSW investigate and, if practicable, establish a resource document setting out the names of First Nations elders and First Nations organisations, being those who can provide mentoring support to First Nations inmates subject to an ISP or RIT management plan. Such culturally appropriate mentorship and support is to occur whilst the inmate is on the plan.

406. In regard to a recommendation that "*If such a resource is established, rather than restricting access to it to First Nations inmates subject to an ISP or RIT, other First Nations inmates who are struggling to adjust to their environment and situation should have free access so that they receive culturally appropriate support as needed*", I agree with CSNSW that this recommendation does not arise from the evidence in this inquest. I consider it is not sufficiently connected to Bailey's death, as required by s. 82 of the *Coroners Act 2009*, to cause the recommendation to be made. However, in my view, if such a resource exists for inmates on an ISP or RIT, it may prevent a First Nations inmate from escalating so that an ISP or RIT is required. If the list is available, access to it should not be restricted to those on an ISP or RIT, and other First Nations inmates who are struggling to adjust to their environment and situation should have free access so that they receive culturally appropriate support as needed. I note that CSNSW has already agreed to explore whether this proposal could be implemented, and I implore them to do so.

Recommendation CS 7

407. Ms Lewer put forward a recommendation that requires CSNSW to respond to a request made by an inmate (who is on a RIT and accommodated in an assessment cell) to see a nurse, psychologist or psychiatrist, by communicating and facilitating such request. CSNSW submits that although they cannot compel Justice Health staff to attend upon an inmate, it can communicate where practicable such requests.

408. I think such a recommendation is necessary but I amend that put forward by Ms Lewer as follows:

> Recommendation CS 7

That CSNSW amend policy and procedure to:

i. Ensure that when an inmate in an assessment cell requests to see a nurse, psychologist or psychiatrist, that such request be communicated to the nurse, psychologist or psychiatrist.

ii. In the event that such person declines to attend, a written note to that effect should be made in OIMS.

iii. If a nurse, psychologist or psychiatrist declines to attend, the inmate should be provided the opportunity to make a call to the 1800 Mental Health Helpline and this should be recorded in OIMS.

Recommendation CS 8

409. Ms Lewer and Mr de Mars put forward a recommendation to amend CSNSW policy so that case notes about the deterioration or progress of an inmate in an assessment cell are made in OIMS.

410. CSNSW supports the submission in a modified form. I make the recommendation reflecting that modified form:

Recommendation CS 8

That CSNSW amend its policy to require documentation in OIMS of observations by CSNSW staff of an inmate's behaviour, progress or deterioration while placed in an "assessment cell", with such documentation to be recorded on an hourly basis, and that there be an obligation on change of shift for there to be a verbal handover regarding the observations made about the inmate during that shift.

Where competing shift duties do not permit such records to be made each hour, entries are to be made as duties permit, and an end of shift record must be made, noting the observations of the inmate during the shift.

Where no verbal handover is possible, the incoming staff member should review the OIMS of any inmate housed in an assessment cell, at their earliest convenience, in relation to their presentation over the period of their placement in the assessment cell.

Recommendation CS 9

411. Ms Lewer put forward a recommendation addressing the actions that should be taken when an inmate in an assessment cell appears to be deteriorating. CSNSW supports the recommendation but helpfully had modified it and I make the recommendation as modified:

Recommendation CS 9

That CSNSW amend its policy to require CSNSW staff to contact the on-duty Justice Health staff member if an inmate's physical and/or mental health is observed to deteriorate while housed in an "assessment cell".

Recommendation re consent to share health information

412. Ms Lewer advances a recommendation in relation to inmates providing consent for the sharing of information with third parties and consent for the sharing of health information between Justice Health and CSNSW. Both these recommendations (initially numbered as 16a and 8j respectively) are opposed by CSNSW.

413. I agree with the CSNSW submission that consent should be provided at the time it is required and not as a global preamble at reception into custody or a CC. Evidence in the inquest was clear that privacy requires consent to be up-to-date and specific, so it would be inappropriate to rely on consent at a time earlier than when the specific incident arose. I decline to make recommendations relating to generalist consent authorities.

414. The recommendation initially numbered as 16a is considered with respect to Justice Health at [472]-[474].

Recommendation CS 10

415. Ms Lewer advances recommendations that CSNSW immediately cease the use of the assessment cells at Kariong CC, or in the alternative that CSNSW conduct an urgent review of the adequacy of such cells and any risks associated with their use. Further, she advances a recommendation that CSNSW repair and make fit for purpose the exercise yards attached to the assessment cells at Kariong. She also supports a review into whether cl. 53 of the Regulation is being complied with, (and if not, why not).

416. Those recommendations are opposed by CSNSW on the basis that Kariong CC assessment cells are intended to address immediate concerns of risk of harm, there are insufficient alternative resources to deal with such needs, and the limitations of the assessment cells are known but there are resourcing issues involved in addressing those limitations. That submission countenances the disregard of least restrictive options which is mandated in the policy. That the Kariong CC assessment cells are still being used with the known limitations is not appropriate.

417. I make the following recommendation:

> Recommendation CS 10
>
> CSNSW is to address the use of assessment cells at Kariong Transit and Intake Centre ("Kariong TIC") to ensure that they are fit for purpose. Until such time that Kariong TIC is able to provide an inmate on a RIT with access to their entitlement per cl. 53 of the Regulation for daily open air exercise, an inmate who would otherwise be housed in an assessment cell at Kariong TIC should be immediately transferred to a correctional centre which can provide for the placement option of least restrictive care whilst they are at risk of self-harm.

Recommendation CS 11

418. Finally, Ms Lewer put forward a recommendation that CSNSW conduct a review into the use of isolation to manage inmates at risk of self-harm and whether this is consistent with best psychiatric and psychological practice.

419. CSNSW opposes that recommendation on the basis that "*[t]he decision to use a safe cell is not a psychological or psychiatric practice but a short term security response*".

420. The evidence in this inquest highlights the need for CSNSW to balance the correctional duty of care with the psychological or psychiatric wellbeing of the inmate at risk of suicide. It is no response to place an inmate suffering a mental health condition into a cell as a short-term security response without meaningful and timely mental health intervention. That such intervention was not available to Bailey demonstrates that the appropriate balance was not achieved. It is necessary that CSNSW seek to achieve it, and when it is not in place, to improve the system.

421. Accordingly, I am of the view that the use of isolation to manage inmates at risk of self-harm, outside of the Acute Crisis Management Unit ("ACMU") use of assessment cells, should be subject to an evaluation and review with a view to improving the balance so that inmates do not see it as a punishment worse than segregation.

422. I make the following recommendation:

> Recommendation CS 11
>
> That CSNSW conduct a review into the use of assessment cells to manage inmates at risk of self-harm and whether such use is consistent with adherence to the concept of least restrictive placement options. Such review should also include whether RIT Management Plans appropriately allow for diversionary activities and

> human interaction as contemplated by the policy, and whether appropriate mental health interventions are being provided to the inmates whilst in the assessment cell.

Recommendation CS 12

423. Counsel assisting puts forward a recommendation in relation to CSNSW providing its staff with training regarding the management of persons placed on a RIT and in an assessment cell, as suggested by Mr Hovey in his investigation report. Ms Lewer puts forward a recommendation that CSNSW staff be required to undertake ongoing training and development in relation to managing acutely distressed inmates and inmates in assessment cells. Such training would include methods and strategies that might be able to be utilised to assist the inmate, how to make observations and report about inmates, the supports and resources that are available and arranging appropriate follow-up for the inmate.

424. CSNSW opposes the recommendations on the basis that CSNSW staff already undertake training and that a generalised approach would mean a poorly targeted education programme. I agree. The evidence in the inquest indicates that there needs to be a document to assist those who are charged with monitoring and managing a distressed inmate in an assessment cell and when to re-visit the terms of the management plan to address the stress.

425. Accordingly, the recommendation I consider as necessary is as follows:

> Recommendation CS 12
>
> That CSNSW develop a document to provide guidance and structure to officers charged with the task of monitoring and managing an inmate on a RIT in an assessment cell, so that any deterioration in the inmate's condition can be appropriately escalated and managed and further, so that a proper record is kept of the inmate's progress. This document is to be provided to the co-ordinator of the RIT review meeting and a copy to the manager responsible for the inmate at the time of that review.

Proposed recommendation regarding information to provide hospital

426. Mr de Mars advanced a recommendation requiring medical escort officers to provide a hospital with information that an inmate is subject to a Mandatory Notification, ISP or RIT. This is opposed by CSNSW on the basis of the issue of consent. I agree that such information should not be conveyed unless it is relevant to the immediate safety of the care and treatment of the inmate. If the inmate is able to communicate consent,

then it is open to the inmate to inform the hospital of their status. I decline to make the recommendation sought.

Recommendation CS 13

427. Counsel assisting advanced a recommendation as follows:

> *"That CSNSW staff who are likely to communicate with the family or support person for an inmate, such as psychologists, services and programs officers and administrative staff, are provided with guidance and any necessary training on effective communication with an inmate's family or support person, the boundaries of confidentiality and the avenues for obtaining consent when necessary".*

428. The recommendation is opposed by CSNSW because:

> *"CSNSW understand that this recommendation is designed to address the concept that receipt of information from third parties may not impact on consent. That is, a person can obtain information without breaching confidentiality and in circumstances where there is no known consent to reveal information pertaining to the inmate generally or specifically to their medical and incarceration matters, and then use that information to help make an informed management / medical decision.*
>
> *On this understanding, the recommendation is opposed.*
>
> *Psychologists and Nurses undergo extensive university and post studies training to qualify. Even with this training, the evidence of the experts was that the question of consent is a difficult issue. In the circumstances, this recommendation is not supported given the lack of clarity as to what the recommendation is intended to capture in so far as it relates to the difficultquestion of consent. Consideration can be given to devising a new training module looking to communication with inmate's families / support persons."*

429. It is necessary to make a recommendation in stronger terms than that proposed by CSNSW. Accordingly, I make a recommendation as follows:

> <u>Recommendation CS 13 (a)</u>
>
> CSNSW is to develop an appropriate training module and guidelines to assist staff (including but not limited to psychologists, SAPOs and relevant senior officers) to communicate with family members who are making inquiries about an inmate's wellbeing. That training package is to be rolled out across CSNSW correctional centres.
>
> i. That training should include, but not be limited to:
>
> a) that the CSNSW Family Handbook advises family members when they are entitled to contact a correctional

centre in order to provide information about an inmate (see Recommendation CS 13(b));

b) accepting a telephone call, ascertaining what the inquiry is, taking the name and contact details of the caller and prioritising the urgency of attending to the family's request;

c) understanding the difference between gathering information and giving information;

d) defining what information can be given without written consent;

e) defining what information cannot be given without written consent;

f) determining an appropriate time frame within which any required written consent is obtained from the inmate;

g) the process by which such consent is to be sought and obtained, including what should be specified on the consent form;

h) documenting information provided to a family member; and

i) documenting information provided by a family member and to whom it should be given.

ii. That training should include scripts, consent forms, practical role plays and scenarios.

430. Further to the issue of family inquiries, counsel assisting suggested a recommendation addressing the amendment of the CSNSW Family Handbook, which CSNSW supports in modified form.

431. I now make that modified recommendation:

> Recommendation CS 13 (b)
>
> That CSNSW amend the 'Families Handbook' to clearly identify that a family member or support person is entitled to contact a correctional centre in order to provide information about an inmate's medical health including mental health in urgent or important circumstances. All contact should be initially made to the Justice Health and Forensic Mental Health Network 24 hour hotline – ph: 1800 222 472, and then alternatively to the Functional Manager on duty of the correctional centre where the inmate is detained, or a SAPO on duty at that centre.

432. In addition, I make the following related recommendation:

Recommendation CS 13 (c)

That as soon as practicable CSNSW send an email memorandum to appropriate staff members reminding them that family members are entitled to contact a correctional centre in order to provide information about an inmate's medical health including mental health in urgent or important circumstances and accordingly those telephone calls should be accepted and actioned.

Professional Standards

433. The last recommendation to CSNSW to be addressed is one put forward by Mr de Mars:

> "*These findings and transcript of these proceedings be reviewed by the Conduct and Professional Standards Unit and the Professional Standards Branch of Corrective Services NSW to consider whether any disciplinary or other remedial action should be taken in relation to officers Lloyd and Dolling concerning their involvement in the RIT review process*".

434. This is opposed by CSNSW for these reasons:

> "*CSNSW takes responsibility for placing Rick Lloyd in a role he was not trained for. His conduct was not tainted by malice or any mal fides. At most he was unaware of a policy he would have been aware of had CSNSW provided him with the required training to take on that role. Correctional Officer Terry Dolling was not part of the RIT process was invited to express his views to the RIT Team. The decision lay with the RIT team. CO T Dolling cannot be criticised for expressing his view, in circumstances where he was not the decision maker and not a member of the team*".

435. I accept that Mr Lloyd did not appreciate that he was not trained to be a RIT co-ordinator. Ultimately, one might expect that as a senior and experienced correctional officer he would have exercised common sense and due diligence and opened the red folder (containing RIT information, policies and forms) sitting on the desk in his office to ascertain what was required of him. However, given that CSNSW takes responsibility for placing an untrained staff member in that position, it is a matter that falls short of being referred.

436. The same cannot be said for Mr Dolling. I do not accept CSNSW's submission that Mr Dolling was invited to participate in the RIT review meeting. The evidence is clear that he imposed himself on the meeting and due to his status, he over-rode the RIT review process and dictated that Bailey was either in the assessment cell or off the RIT management plan. He did so without any knowledge of, or regard to, CSNSW policy.

437. The result was that Bailey was not only incarcerated in the assessment cell for period/s that he otherwise would not have been, but he was also deprived of any human interaction and human contact diversionary activity – which was a stepping up, not a stepping down, of the conditions of his incarceration as contemplated by Ms Thompson and RN Georgiou. On that basis, the effect was that Bailey's treatment was punitive and unjustified.

438. Mr Dolling denied having any engagement with the RIT review process when he clearly did and would have clearly remembered doing so. I find that is highly suggestive that he realises his wrongdoing but does not want to admit to it. Those circumstances do warrant a referral to the Conduct and Professional Standards Unit and the Professional Standards Branch of CSNSW. Recommendations are not the appropriate vehicle for such process; rather, I will cause a letter to be forwarded to the appropriate member of CSNSW together with a copy of these findings. I expect that the units have their own means to access the relevant parts of the transcript, but if not, arrangements can be made with Coroners Court of NSW registry.

Joint recommendations to Justice Health and CSNSW

Joint Recommendations CS/JH 1 and 2

439. Counsel assisting put forward joint recommendations to Justice Health and CSNSW, which are not opposed. I make recommendations as follows:

> Joint Recommendation CS/JH 1
>
> That Justice Health and CSNSW liaise and ensure that their respective websites and the relevant part of the 'Families Handbook' are consistent with the following information:
>
> i. that a family member or support person is entitled to contact a correctional centre in order to provide information about an inmate's medical health including mental health in urgent or important circumstances; and
>
> ii. that all contact should be initially made to the Justice Health and Forensic Mental Health Network 24 hour hotline – ph: 1800 222 472, and then alternatively to the Functional Manager on duty of the correctional centre where the inmate is detained, or a SAPO on duty at that centre.
>
> Joint Recommendation CS/JH 2
>
> That Justice Health and CSNSW convene a joint working group for the purpose of improving the current custodial mental health model

of care, with specific focus on the provision of multidisciplinary, integrated, evidence-based healthcare with shared health records

Joint Recommendation CS/JH 3

440. Counsel assisting put forward a recommendation that when CSNSW raises a Mandatory Notification, the inmate is to be given an opportunity to provide consent for Justice Health staff to communicate with a third party. That would be parallel to the recommendations to CSNSW at Recommendation CS 3(b)(iv)-(v) above (which relate to providing CSNSW consent to speak to a third party).

441. This was amended by Mr de Mars to include a proviso that once the consent was provided, Justice Health would contact the inmate's nominated support person and provide them with information relating to the inmate's RIT status and cell placement, information regarding the RIT review process, and appropriate details to enable them to contact a member of Justice Health during the currency of the ISP or RIT.

442. Mr Rooney on behalf of Justice Health correctly identifies that this task is not one for a Justice Health nurse, but rather a CSNSW SAPO. Mr de Mars' proposed recommendations in relation to CSNSW did not suggest that this task be undertaken.

443. The recommendation does not, by its terms, intend that there be a systemic notification of all ISP or RIT approved support persons or third parties. That is, not all inmates who have a nominated support person will give consent to that person being notified. Accordingly, the recommendation only relates to instances where an inmate provides consent. If an inmate is to be given a telephone call to the approved support person, there is no reason why an inmate cannot, if they so choose, provide that information to the support person themselves.

444. For those reasons, I do not recommend that upon the making of a Mandatory Notification that the policy include the recommendation put forward by Mr de Mars.

445. Justice Health is under an obligation to create an HPNF when an inmate changes cell placement. Though that was not done in Bailey's case on 4 November 2019, it is unclear whether it was due to a systemic failure (in that the cell placement was not appropriately conveyed to RN Georgiou), it was an oversight or that she did not have time to complete the HPNF.

446. Not all Mandatory Notifications, ISPs or RIT plans involve an inmate cell placement – only those where the inmate is placed in an assessment cell do. It is therefore unclear how Justice Health is notified that an inmate is on an ISP, and whether Justice Health

is required in those circumstances to create an HPNF. Given that any staff member (from Justice Health or CSNSW) can raise a Mandatory Notification, but only CSNSW are involved in an ISP, it is important that Justice Health are appraised that there is an inmate who is at risk of harm. It may be that the inmate has not even been seen by a psychologist or a Justice Health staff member. According to Ms Mahony's submission, CSNSW see an inmate's risk of harm as a security issue rather than a psychiatric or psychological issue. However, it is in fact a health issue that Justice Health should be informed of.

447. Accordingly, I make the following recommendation:

> Joint Recommendation CS/JH 3
>
> That CSNSW and Justice Health liaise and create mutual policy and procedure (to the extent not otherwise contained in the respective organisations' policies) so that when a Mandatory Notification is raised and an ISP is created, a notification is provided by CSNSW to Justice Health. Further, Justice Health is to create a policy whereby, upon receipt of that notification, a Justice Health nurse will attend upon the inmate. That Justice Health nurse will inform the inmate that Justice Health are aware of their ISP or RIT status, discuss consent to sharing health information (as set out in Recommendation JH 1) and obtain information to create the HPNF, as well as ascertaining and administering to the inmate's health needs.

Recommendations to Justice Health

Consent for JH to communicate to third party - Recommendations JH 1 and 2

448. In relation to the issue of consent, I make a recommendation consistent with that contained in Recommendation CS 3(b)(iv)-(viii):

> Recommendation JH 1 (a)
>
> Further to Joint Recommendation CS/JH 3, that Justice Health introduce policy and procedure to include that when a Justice Health nurse conducts an initial attendance upon an inmate they have been notified is on a Mandatory Notification/ISP or RIT that the Justice Health nurse:
>
> i. Inform the inmate that they can now, or at any stage whilst on the ISP or RIT, provide written consent for Justice Health staff to communicate with specified third party(ies) for the duration of or any specified part of the ISP or RIT, with that consent to indicate the parameters, if any, of information to be provided.
>
> ii. Inform the inmate that such consent will be documented

appropriately in their Justice Health file and retained in the event that it is useful or necessary for the management and support of the inmate on the ISP or the RIT.

iii. Inform the inmate that they may withdraw their consent in writing at any time and, that where there is a withdrawal of consent, that will be documented on their file and retained with the inmate's ISP or RIT documentation.

iv. Provide an opportunity for the inmate to provide such consent for the duration of, or a specified part of, the ISP or RIT.

v. Request the inmate to sign an acknowledgement that the above has been explained to them and that they understand the process. In the event that an inmate does not wish to sign, the Justice Health staff member should record this fact and any reasons expressed by the inmate as to why they do not wish to sign.

vi. Complete the appropriate documentation (with respect to the above) and retain the consent documents.

449. Justice Health oppose a recommendation that would direct third party inquiries about an inmate on an ISP or RIT to Justice Health, unless the inquiry relates to the inmate's health issues. I think that is a reasonable position. I note that Joint Recommendation CS/JH 1 addresses this issue. As far as the proposal that such health inquiries be directed to the Justice Health Nursing Unit Manager at first instance, rather than a Justice Health nurse, I decline to do so as the resources vary on a day-to-day basis.

450. Ms Lewer puts forward a recommendation that CSNSW and Justice Health develop a list of psychologists, psychiatrists and mental health nurses who can speak via telehealth to inmates in an assessment cell.

451. Mr Rooney's response to this recommendation was on a misapprehended basis that it was directed to a nurse speaking to those individuals; however, it is for the inmate to speak to them. ROAMS is not available to inmates directly. I decline to make the recommendation but make this recommendation:

Recommendation JH 1 (b)

At the time that Justice Health attends a patient placed on an ISP or RIT, the nurse is to provide to the patient with the phone number for the Mental Health Helpline.

452. Justice Health agree to the proposed recommendation in relation to staff training regarding effective communication with third parties. I make the following recommendation:

> Recommendation JH 2
>
> That Justice Health staff who are likely to communicate with the family or approved support person for an inmate, including clinical and administrative staff, are provided with guidance and any necessary training on effective communication, the boundaries of confidentiality and the avenues for obtaining consent when necessary; such training should include the use of scripts, consent forms, practical role plays and scenarios.

Justice Health Member on RIT Review Team - Recommendation JH 3 (a)

453. Counsel assisting puts forward a recommendation (amended by Mr de Mars) that the Justice Health nurse who sits on the RIT review team be a mental health nurse.

454. Justice Health submits that sometimes this does occur, but there are insufficient resources to ensure that there is a mental health nurse on site and that they are able to sit on a RIT.

455. Whilst I acknowledge the training and experience of registered nurses, it is preferable that if there is an available mental health nurse on site, ideally they should participate in the RIT review meeting.

456. The extremely limited resource situation for Justice Health to provide adequate provide staff to meet the mental health needs of inmates is similar to CSNSW's resources in relation to the provision of psychological services, in that they simply are under-resourced. Again, I acknowledge that the manner in which public funds are to be allocated is appropriately left to members of the executive government and as the advancement of the recommendation is dependent upon such funding I am unable to advance it any terms other than as follows:

> Recommendation JH 3 (a)
>
> That Justice Health give consideration to developing a protocol to ensure that when a Justice Health staff member participates in a RIT review meeting that member is, if available, a mental health nurse and if not, that the participating member has access and opportunity to consult with mental health staff either at the centre or via Remote Off-site After-Hours Medical Services ("ROAMS")

Justice Health documents

457. Counsel assisting advances a recommendation that Justice Health amend its policy to permit a Justice Health nurse to provide a RIT co-ordinator with copies of clinical notes for the purpose of the meeting.

458. This is not supported by Justice Health and Mr Rooney points out that the implicit role of the Justice Health member is to present relevant health information to the RIT and that they have expertise in communicating an accurate clinical picture.

459. In terms of privacy and confidentiality, it is difficult to see the difference between a third party reading clinical notes and a third party being told about what is in those notes. However, as Dr Spencer said, "*it is a … minefield*"[336]. Is seems that the minefield is also related to a siloing effect. I also note that the RIT review meeting records are to be kept by CSNSW as a hard copy; it is preferable that those records, other than the HPNF, are not distributed of outside Justice Health.

460. Accordingly, I decline to make that recommendation.

On-call psychiatrist and mental health referrals

461. Counsel assisting proposed a recommendation that Justice Health ensure that Justice Health Nurses in all correctional centres can directly seek and obtain the services of an on-call psychiatrist on an urgent basis, for a consultation with an inmate when deemed clinically necessary.

462. Justice Health's response indicates that such a recommendation is unnecessary, as such a system is available through ROAMS (as there is a 24/7 on-call psychiatric registrar and if an emergency consultation is required that can probably be organised for the next day, even via telehealth).

463. Bailey did not need to see a psychiatrist; he needed psychological support. On 4 November 2019, this was not made available to him, apparently out of hope that he would settle and a fear that he might escalate. On 5 November 2019, there was no psychologist on site at Kariong CC. Ms Thompson might have helped, but correctional staff did not request her services, preferring to manage Bailey in their own fashion. RN Georgiou, on two occasions on 5 November 2019, consulted a GP via ROAMS but the issue of whether Bailey should be given sedating medication was not indicated because he was pretending to be unconscious rather than expressing agitation.

[336] Transcript 21/10/21, T385.31.

464. I decline to make the recommendation.

465. A more useful recommendation is that where a RIT management plan indicates a referral to a mental health nurse for assessment, that this referral be expedited. Accordingly, I make the following recommendation:

> Recommendation JH 3 (b)
>
> That Justice Health give consideration to implementing a priority referral system for any mental health referrals contained in a CSNSW RIT Management Plan.

Handover material from Justice Health to hospital for transfer of inmates on an ISP or RIT

466. Mr de Mars puts forward a recommendation relating to the Hospital being informed that an inmate is on a RIT. The intent behind this recommendation is really to require public hospitals to engage in the provision of mental health services that might otherwise be provided by Justice Health (in an ideal world), in a timely fashion.

467. Bailey's RIT Management Plan indicated a referral for a mental health assessment by a mental health nurse. Justice Health records indicate there was a need for such assessment prior to Bailey being transferred to Kariong CC. A mental health assessment would not occur on an urgent basis. In Bailey's case, the referral to a mental health nurse on the RIT Management Plan was not actioned, so it is understandable that Bailey's family would expect that if he was going to hospital (where those services are available) that they should be provided. This is especially so given that otherwise, those services were never going to be provided to Bailey in a timely manner.

468. When Bailey told Mr Cargill that he had swallowed the batteries and razor blades, Mr Cargill made due inquiry. His position was that he did not really believe that Bailey had in fact swallowed them, but after receiving advice from Terence Joseph (the AHNM), Mr Cargill organised for Bailey to attend hospital.

469. Professor Large said that Bailey would not have been assessed as mentally ill or disordered. I accept that is the case. To mandate that a hospital take into account that a person has been assessed as at risk of self-harm, where that assessment involves duty of care and security issues rather than psychological and psychiatric issues, is rife with problems. I do, however, understand the sentiment behind the proposed recommendation.

470. In response to this proposed recommendation, Justice Health indicates that when a transfer to hospital occurs and there is an onsite Justice Health nurse, the nurse completes a referral form and that accompanies the patient to hospital. When the transfer to hospital occurs on an unplanned after-hours basis, no such referral form is completed by Justice Health and provided to the hospital. Mr de Mars says that this is a gap that should be filled. I am not convinced that an AHNM referral would have contained any further information as to why Bailey was presenting to hospital than that indicated by Mr Cargill.

471. Accordingly, I decline to make this recommendation.

Further recommendations proposed by Ms Lewer

472. Ms Lewer puts forward the following three recommendations:

i. Where CSNSW does not have sufficient or appropriate in-patient facilities for an acutely mentally ill or mentally disordered inmate within the forensic environment, Justice Health is to implement s. 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* on every occasion it is so required and arrange for the immediate transfer of the inmate to the nearest available mental health facility.

ii. Justice Health undertake a review of the level of psychiatric care provided to inmates in correctional centres in NSW, with the aim of comparing that level of care to the level the person would have received if they had been in the community setting, and to identify the resourcing and other actions that would be required to provide a similar level of care in a custodial setting.

iii. Justice Health conduct a review into admission procedures at CCs to investigate whether recommendations about an inmate's mental health treatment are being implemented within an appropriate time frame at the new facility and, if not, why that is not occurring.

473. I decline to make these recommendations, as the consideration of each does not arise from evidence in this inquest.

474. A final recommendation proposed by Ms Lewer is:

> "*That CSNSW and Justice Health implement a policy that at the time of reception into each correctional centre, inmates be automatically provided consent forms that permit Justice Health and/or Corrective Services to share information relating to the inmate with nominated family member(s) or friend(s) of the inmate. Such a form shall include an area whereby the inmate can specify whether it is all information or whether some specified information is or is not to be disclosed and how consent can be revoked*".

475. I refer to this recommendation above at [410]-[411] with respect to CSNSW.

476. I adopt Justice Health's suggested recommendation in response:

> Recommendation JH 4
>
> That Justice Health give consideration to seeking a joint legal authoritative legal advice addressing the limits and risks of a revokable but enduring consent, in the context of improving the sharing of patient information in custodial health.

Joint recommendation to Central Coast Local Health District ("LHD") and Justice Health

477. Mr de Mars' proposed recommendation to the Central Coast LHD is accepted. The recommendation is desirable to improve local hospital staff understanding Justice Health's role in CSNSW system. The recommendation will also be made to Justice Health. I make the following recommendation:

> Recommendation Joint CCLHD/JH 1
>
> That a copy of the "*Who is JHFMHN*" poster developed by Justice Health be circulated to all New South Wales Health Emergency Departments, and for that document to be brought to the attention of hospital staff to ensure they are aware of relevant contact information to assist where necessary with clinical handover.

Proposed recommendation to the Attorney General

478. Ms Lewer directs a proposed recommendation to the (NSW) Attorney General as follows:

> "*Consideration be given to funding the Mental Health Advocacy Service to provide information, advice, assistance, and representation to inmates being managed on an ISP/RIT".*

479. There is no doubt that the use by CSNSW of assessment cells for the security and management of inmates at risk of self-harm and suicide, without procedural safeguards such as a decision review process (which is available to inmates placed in

segregation), and coupled with a dearth of psychological and support services, is a highly undesirable situation.

480. The tragic irony is that the smaller financial commitment to provide better psychological and welfare services to assist inmates, especially the vulnerable young First Nations men who are so gravely over-represented in the prison population, would likely not only result in saving community costs but would save lives, spare trauma and self-harm, and lessen incarceration.

481. As indicated previously, I acknowledge that the manner in which public funds are to be allocated is appropriately left to members of the executive government. As the advancement of the recommendation is dependent upon such funding I am unable to advance it in the terms sought. In addition, the Attorney General was not a party to the current proceedings, and as such I will not direct a recommendation to him.

Inspector of Custodial Services

482. I have considered taking the course of recommending that the Inspector of Custodial Services NSW undertake a review or audit of the use of RIT and assessment cells in the general population (as distinct from the ACMU). On balance, it is not for a coroner to make any such recommendation to the Inspector, but I will request the Coroners Court registry ensure that these findings are forwarded to the Inspector's office (which I am confident would, in any event, be read by the Inspector in the normal course of business).

Conclusion as to recommendations

483. The list of recommendations are located at the end of these findings (Appendix A).

Findings

484. I now enter the findings required to be entered pursuant to s. 81 of the Act as follows:

Identity Bailey Mackander was a 20 year old Wiradjuri man.

Date of Death 7 November 2019

Place of Death Royal North Shore Hospital, St Leonards, NSW

Cause of death Multiple injuries from fall from height

Manner of death

Bailey was on remand in the lawful custody of CSNSW and died after he impulsively ran from the custody of CSNSW escort officers and vaulted over the Gosford Hospital ambulance bay wall without realising that the wall was not at ground level but was approximately eight metres above. At the time Bailey escaped he was handcuffed and ankle shackled and was subject to a Risk Intervention Team Management Plan which caused him to be held in an assessment cell. Whilst in the assessment cell that day, he was without any psychological or social support or access to the open air and was deprived of any diversionary activities involving human interaction and telephone calls. Bailey had a substance use disorder in conjunction with or additional to a generalised anxiety disorder. He struggled with being in prison and he especially struggled with being in the assessment cell. He fabricated stomach pains and a story that he had swallowed metallic foreign objects to attend hospital so that he could have time away from the cell. His escape was impulsive in circumstances where he knew he was about to enter the escort vehicle to return to the cell, without any certainty that he would be discharged from that cell the following day.

Conclusion

485. This inquest has been a tragic and sad learning of the last days of a young gentle man who was really still a boy. Bailey's teenage years of drug use did not turn his family away, but it resulted in him going to prison and it resulted in him not developing as he otherwise would have. To have the emotional skills to deal with the trauma of prison is not easy when you are young. Perhaps it is not easy anytime. It was Bailey's connection to his family that helped him cope with being in prison. He spoke to his mum on the telephone every day. He wrote to his dad and told him how much he loved him and that this time he was going to stop the drugs for sure. No matter how many times they heard Bailey say that, his family did not turn their back on him.

486. Bailey was not some prisoner who nobody cared about. Yet his mother's desperate calls to the prison were dodged and unanswered. Bailey's connection to his family was severed in the name of protecting him from harming himself. It was careless. Nobody recognised or considered that more harm than good was being done to Bailey by the terms of the RIT management plan. He was expected to tough it out. Suck it up. Bailey was not thinking when he took off over that wall - he was being driven by sudden impulse and emotion. Perhaps they are the things that can't be imprisoned.

487. As I said after hearing Bailey's parents speak of him, something has to change. These findings and recommendations will not stop the courts sending young Baileys to prison. They will not cause the correctional system to cater for all kinds in better and more ways or cause the government to invest more money in alternatives so that young people with drug problems are not treated like criminals and I suspect they will not even result in better mental health and psychological support in prisons which are full of people who need it. But perhaps they will save one or two from being placed in a RIT cell to battle their demons alone. To the Mackander family, I am so very sorry for your loss.

488. The inquest is now closed.

Magistrate E Truscott
Deputy State Coroner
15 December 2021

Appendix A

Inquest into the death of Bailey Mackander

Recommendations made pursuant to s. 82 of the *Coroners Act 2009*

Recommendations to CSNSW

Recommendation CS 1

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to require a co-ordinator of a RIT review meeting to seek that a psychologist be a member of the RIT and in the event that the psychologist is unable to participate in the review meeting, provide an opportunity for the SAPO and/or Justice Health member of the team to consult with the centre's psychologist or an off-site mental health service provider, prior to any determination of the RIT review team.

Recommendation CS 2 (a)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to indicate that the RIT coordinator is required to compile and distribute a folder of specified documents to the RIT members prior to the RIT review meeting in sufficient time so that those members are informed of the matters contained therein. The documents are to include:

i. the Part 1 Mandatory Notification;
ii. prior Mandatory Notifications, ISPs and RIT plans;
iii. recent OIMS case notes with regard to the mental health of the inmate;
iv. any observations of the inmate in a cell made while on an ISP or a RIT; and
v. current OIMS alerts in relation to the inmate.

Recommendation CS 2 (b)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to provide that any ISP and RIT Management Plan must include written reasons as to the following:

i. the decision to place the inmate on the ISP or the RIT;
ii. the cell placement, including reasons why a less restrictive placement option, if available, is not suitable; and
iii. if a less restrictive placement option is unavailable at the time, why that option is unavailable and when, if ever, it will be available.

Recommendation CS 2 (c)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to provide the following:

i. That any ISP and RIT management plan identify in writing the names of the person/s and/or designation of office who will be responsible for the management of the inmate on the relevant shifts until the next RIT review; and

ii. that this information is provided to the inmate.

Recommendation CS 3 (a)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to provide the following:

i. That an inmate placed on an ISP is to be provided the opportunity to have telephone contact with an approved support person (approved by the governor or delegate). Such telephone contact by the inmate is to be facilitated as soon as possible - preferably within two hours - of the inmate being placed on an ISP.

ii. That a phone call from an inmate to an approved support person be facilitated at the establishment of a RIT Management Plan and upon each 24 hour extension of such plan.

iii. That a phone call from an inmate to an approved support person be facilitated at the discharge from an ISP or upon the establishment of a RIT discharge plan.

iv. The policy should clarify that any additional telephone calls to an approved support person are to be at the discretion of the officer managing the inmate.

v. The policy should make it clear that these telephone calls are not a substitute for any telephone calls for the purpose of human contact or interaction as set out in the ISP or RIT management plan or discharge summary.

Recommendation CS 3 (b)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to include that as soon as practicable following a Mandatory Notification, the managing officer is to:

i. Inform the inmate of the decision and the reasons for the MNF and the ISP components.

ii. Inform the inmate that they are entitled to have telephone contact with an approved support person. If the inmate wishes to do so, they are to provide the name and phone number of that person and once approved by the governor or delegate, a phone call by the inmate to that approved support person is to be facilitated as soon as possible (this should occur within hours of being placed on a ISP or RIT Management Plan). If the inmate does not wish to nominate a person, that should be recorded in writing.

iii. Inform the inmate that their ISP or RIT status will be subject to review within 24 hours and that they will attend the meeting of the review team to discuss their level of risk of harm and any protective factors and safeguards that can be put in place so that they could be discharged from the ISP or RIT.

iv. Inform the inmate that they can now, or at any stage whilst on the ISP or RIT, provide written consent for CSNSW staff to communicate with specified third party(ies) for the duration of or any specified part of the ISP or RIT, with that consent to indicate the parameters, if any, of information to be provided. Further, they are to inform the inmate that this will be documented appropriately in OIMS and retained with the inmate's RIT documentation in the event that it is useful or necessary for the management and support of the inmate on the ISP or the RIT.

v. Inform the inmate that they may withdraw their consent in writing at any time and, that where there is a withdrawal of consent, that will be documented in OIMS and retained with the inmate's ISP or RIT documentation.

vi. Provide an opportunity for the inmate to provide such consent for the duration of, or a specified part of, the ISP or RIT.

vii. Request the inmate to sign an acknowledgement that the above has been explained to them and that they understand the process. In the event that an inmate does not wish to sign, the officer should record this fact and any reasons expressed by the inmate as to why they do not wish to sign.

viii. Complete the appropriate OIMS documentation (with respect to the above) and retain the consent documents.

ix. Notify Justice Health that an inmate is on an ISP or RIT (see also, Joint Recommendation CS/JH 3).

Recommendation CS 3 (c)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to require the following:

i. each RIT review member is to sign an acknowledgement of completion of the necessary training to undertake the role;

ii. the co-ordinator is to record the time of the commencement and conclusion of the RIT review meeting;

iii. the co-ordinator is to record the time at which the inmate was in attendance at the RIT review meeting; and

iv. the completion of all sections of the forms is to be carried out with the use of the assessment guideline documents.

Recommendation CS 4

That CSNSW amend the following forms: Part 1 Mandatory Notification Form, Part 2 Immediate Support Plan, and Part 3 Risk Intervention Team (RIT) Management Plan, to incorporate the following (including to facilitate the changed policy set out in Recommendations CS 2 and CS 3):

i. the time at which the inmate is placed in the RIT assessment cell;

ii. the time at which the ISP is commenced and the time/s at which it is completed and/or amended;

iii. an acknowledgement to be signed by each RIT review member of completion of the necessary training to undertake the role;

iv. the times at which those adopting the contents of the form signed, and the legible names of the signator/s; and

v. the time/s at which the inmate attends and departs a RIT review meeting.

Recommendation CS 5

That CSNSW investigate the implementation of a procedural safeguard enabling an approved third party to accompany and assist an inmate when they attend a RIT review meeting, on the basis that the third party would attend by remote facility such as web-conferencing.

Recommendation CS 6

That CSNSW investigate and, if practicable, establish a resource document setting out the names of First Nations elders and First Nations organisations, being those who can provide mentoring support to First Nations inmates subject to an ISP or RIT management plan. Such culturally appropriate mentorship and support is to occur whilst the inmate is on the plan.

If such a resource is established, rather than restricting access to it to First Nations inmates subject to an ISP or RIT, other First Nations inmates who are struggling to adjust to their environment and situation should have free access so that they receive culturally appropriate support as needed.

Recommendation CS 7

That CSNSW amend policy and procedure to:

i. Ensure that when an inmate in an assessment cell requests to see a nurse, psychologist or psychiatrist, that such request be communicated to the nurse, psychologist or psychiatrist.

ii. In the event that such person declines to attend, a written note to that effect should be made in OIMS.

iii. If a nurse, psychologist or psychiatrist declines to attend, the inmate should be provided the opportunity to make a call to the 1800 Mental Health Helpline and this should be recorded in OIMS.

Recommendation CS 8

That CSNSW amend its policy to require documentation in OIMS of observations by CSNSW staff of an inmate's behaviour, progress or deterioration while placed in an "assessment cell", with such documentation to be recorded on an hourly basis, and that there be an obligation on change of shift for there to be a verbal handover regarding the observations made about the inmate during that shift.

Where competing shift duties do not permit such records to be made each hour, entries are to be made as duties permit, and an end of shift record must be made, noting the observations of the inmate during the shift.

Where no verbal handover is possible, the incoming staff member should review the OIMS of any inmate housed in an assessment cell, at their earliest convenience, in relation to their presentation over the period of their placement in the assessment cell.

Recommendation CS 9

That CSNSW amend its policy to require CSNSW staff to contact the on-duty Justice Health staff member if an inmate's physical and/or mental health is observed to deteriorate while housed in an "assessment cell".

Recommendation CS 10

CSNSW is to address the use of assessment cells at Kariong Transit and Intake Centre ("Kariong TIC") to ensure that they are fit for purpose. Until such time that Kariong TIC is able to provide an inmate on a RIT with access to their entitlement per cl. 53 of the Regulation for daily open air exercise, an inmate who would otherwise be housed in an assessment cell at Kariong TIC should be immediately transferred to a correctional centre which can provide for the placement option of least restrictive care whilst they are at risk of self-harm.

Recommendation CS 11

That CSNSW conduct a review into the use of assessment cells to manage inmates at risk of self-harm and whether such use is consistent with adherence to the concept of least restrictive placement options. Such review should also include whether RIT Management Plans appropriately allow for diversionary activities and human interaction as contemplated by the policy, and whether appropriate mental health interventions are being provided to the inmates whilst in the assessment cell.

Recommendation CS 12

That CSNSW develop a document to provide guidance and structure to officers charged with the task of monitoring and managing an inmate on a RIT in an assessment cell, so that any deterioration in the inmate's condition can be appropriately escalated and managed and further, so that a proper record is kept of the inmate's progress. This document is to be provided to the co-ordinator of the RIT review meeting and a copy to the manager responsible for the inmate at the time of that review.

Recommendation CS 13 (a)

CSNSW is to develop an appropriate training module and guidelines to assist staff (including but not limited to psychologists, SAPOs and relevant senior officers) to communicate with family members who are making inquiries about an inmate's wellbeing. That training package is to be rolled out across CSNSW correctional centres.

i. That training should include, but not be limited to:

a) that the CSNSW Family Handbook advises family members when they are

entitled to contact a correctional centre in order to provide information about an inmate (see Recommendation CS 13(b));

b) accepting a telephone call, ascertaining what the inquiry is, taking the name and contact details of the caller and prioritising the urgency of attending to the family's request;

c) understanding the difference between gathering information and giving information;

d) defining what information can be given without written consent;

e) defining what information cannot be given without written consent;

f) determining an appropriate time frame within which any required written consent is obtained from the inmate;

g) the process by which such consent is to be sought and obtained, including what should be specified on the consent form;

h) documenting information provided to a family member; and

i) documenting information provided by a family member and to whom it should be given.

ii. That training should include scripts, consent forms, practical role plays and scenarios.

Recommendation CS 13 (b)

That CSNSW amend the 'Families Handbook' to clearly identify that a family member or support person is entitled to contact a correctional centre in order to provide information about an inmate's medical health including mental health in urgent or important circumstances. All contact should be initially made to the Justice Health and Forensic Mental Health Network 24 hour hotline – ph: 1800 222 472, and then alternatively to the Functional Manager on duty of the correctional centre where the inmate is detained, or a SAPO on duty at that centre.

Recommendation CS 13 (c)

That as soon as practicable CSNSW send an email memorandum to appropriate staff members reminding them that family members are entitled to contact a correctional centre in order to provide information about an inmate's medical health including mental health in urgent or important circumstances and accordingly those telephone calls should be accepted and actioned

Joint recommendations to CSNSW and Justice Health

Joint Recommendation CS/JH 1

That Justice Health and CSNSW liaise and ensure that their respective websites and the relevant part of the 'Families Handbook' are consistent with the following information:

i. that a family member or support person is entitled to contact a correctional centre in order to provide information about an inmate's medical health including mental

health in urgent or important circumstances; and

ii. that all contact should be initially made to the Justice Health and Forensic Mental Health Network 24 hour hotline – ph: 1800 222, and then alternatively to the Functional Manager on duty of the correctional centre where the inmate is detained, or a SAPO on duty at that centre.

Joint Recommendation CS/JH 2

That Justice Health and CSNSW convene a joint working group for the purpose of improving the current custodial mental health model of care, with specific focus on the provision of multidisciplinary, integrated, evidence-based healthcare with shared health records.

Joint Recommendation CS/JH 3

That CSNSW and Justice Health liaise and create mutual policy and procedure (to the extent not otherwise contained in the respective organisations' policies) so that when a Mandatory Notification is raised and an ISP is created, a notification is provided by CSNSW to Justice Health. Further, Justice Health is to create a policy whereby, upon receipt of that notification, a Justice Health nurse will attend upon the inmate. That Justice Health nurse will inform the inmate that Justice Health are aware of their ISP or RIT status, discuss consent to sharing health information (as set out in Recommendation JH 1) and obtain information to create the HPNF, as well as ascertaining and administering to the inmate's health needs.

Recommendations to Justice Health

Recommendation JH 1 (a)

Further to Joint Recommendation CS/JH 3, that Justice Health introduce policy and procedure to include that when a Justice Health nurse conducts an initial attendance upon an inmate they have been notified is on a Mandatory Notification, ISP or RIT that the Justice Health nurse:

i. Inform the inmate that they can now, or at any stage whilst on the ISP or RIT, provide written consent for Justice Health staff to communicate with specified third party(ies) for the duration of or any specified part of the ISP or RIT, with that consent to indicate the parameters, if any, of information to be provided.

ii. Inform the inmate that such consent will be documented appropriately in their Justice Health file and retained in the event that it is useful or necessary for the management and support of the inmate on the ISP or the RIT.

iii. Inform the inmate that they may withdraw their consent in writing at any time and, that where there is a withdrawal of consent, that will be documented on their file and retained with the inmate's ISP or RIT documentation.

iv. Provide an opportunity for the inmate to provide such consent for the duration of, or a specified part of, the ISP or RIT.

v. Request the inmate to sign an acknowledgement that the above has been explained to them and that they understand the process. In the event that an inmate does not wish to sign, the Justice Health staff member should record this

fact and any reasons expressed by the inmate as to why they do not wish to sign.

vi. Complete the appropriate documentation (with respect to the above) and retain the consent documents.

Recommendation JH 1 (b)

At the time that Justice Health attends a patient placed on an ISP or RIT, the nurse is to provide to the patient with the phone number for the Mental Health Helpline.

Recommendation JH 2

That Justice Health staff who are likely to communicate with the family or approved support person for an inmate, including clinical and administrative staff, are provided with guidance and any necessary training on effective communication, the boundaries of confidentiality and the avenues for obtaining consent when necessary; such training should include the use of scripts, consent forms, practical role plays and scenarios.

Recommendation JH 3 (a)

That Justice Health give consideration to developing a protocol to ensure that when a Justice Health staff member participates in a RIT review meeting that member is, if available, a mental health nurse and if not, that the participating member has access and opportunity to consult with mental health staff either at the centre or via Remote Off-site After-Hours Medical Services ("ROAMS").

Recommendation JH 3 (b)

That Justice Health give consideration to implementing a priority referral system for any mental health referrals contained in a CSNSW RIT Management Plan.

Recommendation JH 4

That Justice Health give consideration to seeking a joint legal authoritative legal advice addressing the limits and risks of a revokable but enduring consent, in the context of improving the sharing of patient information in custodial health.

Joint recommendation to Central Coast LHD and Justice Health

Recommendation Joint CCLHD/JH 1

That a copy of the "*Who is JHFMHN*" poster developed by Justice Health be circulated to all New South Wales Health Emergency Departments,and for that document to be brought to the attention of hospital staff to ensure they are aware of relevant contact information to assist where necessary with clinical handover.

Magistrate E Truscott
Deputy State Coroner
15 December 2021