CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of A
Hearing date:	23 - 27 August 2021
Date of findings:	22 October 2021
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death by hanging of a person in custody – was mental health care of an appropriate standard – should a mandatory notification have been made – access to rope and hanging points – adequacy of health information sharing – adequacy of communication for families.
File number:	2018/392964
Representation:	Counsel Assisting the inquest: G Moore of Counsel i/b NSW Crown Solicitor's Office. A's family: E McLaughlin of Counsel, Public Defenders Office, i/b Legal Aid. The Commissioner, Corrective Services NSW: A Mannile, Special Counsel, NSW Department of Communities and Justice Legal. The Justice Health and Forensic Mental Health Network: P Rooney of Counsel i/b Makinson D'Apice Lawyers. M Donaldson: J Kellaway of Counsel i/b McNally Jones Staff Lawyers.

Findings:	**Identity** The person who died is A. **Date of death**: A died on 20 December 2018. **Place of death**: A died at Long Bay Correctional Centre, Matraville NSW 2036. **Cause of death:** The cause of A's death is hanging. **Manner of death:** A died when he hanged himself while in lawful custody, with the intention of ending his life.

Non Publication Orders

Pursuant to section 75 of *the Coroners Act 2009* [the Act], there is to be no publication of any matter that identifies the deceased person and the deceased person's relatives.

Pursuant to section 74 of the Act, non-publication orders have been made in relation to other evidence. A copy of the orders can be found on the Registry file.

In these findings I refer to the deceased person as 'A'.

1. Section 81(1) of the *Coroners Act 2009* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

2. These are the findings of an inquest into the death of A.

Introduction

3. On 20 December 2018 A died in Long Bay Correctional Centre, Sydney. He was 34 years old. A's friend and cell mate R found him unresponsive, hanging from the ceiling of their shared cell. R immediately called for help, but emergency services were unable to revive A and he was pronounced deceased.

4. At autopsy the cause of A's death was identified as hanging.

5. When a person is in custody at the time of their death, an inquest is mandatory pursuant to sections 23 and 27 of the Act. The Coroner must make findings as to the date and place of the person's death, and the cause and manner of death. The Coroner must also examine whether the State has discharged its obligation to provide the person with appropriate care for their physical and mental health.

6. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

7. A's death raised questions about the adequacy of the care he received for his mental health issues while he was in custody. The main areas for examination were the following:

   - why did A not see a mental health nurse, despite being placed on the relevant waitlist?
   - was the treatment and management of A's mental health consistent with relevant policies, procedures and guidelines?
   - where did A get access to the rope which he used?
   - are there appropriate procedures for Corrective Services NSW [CSNSW] and the Justice Health and Forensic Mental Health Network [the JH Network] to share health information about inmates?
   - are there appropriate means for families to communicate their concerns about an inmate's mental health?

A's life

8. A was born in the Republic of the Philippines on 17 November 1984, the first of three children born to his parents. When A was in his late teens his mother moved to Australia. A's father died in 2002, and his mother married

C later that year. She then sponsored A, his sister and his brother to join her in Australia.

9. A arrived in Australia in 2006. By this time he had two children in the Philippines, one of whom has since died. In Australia he lived with his mother, stepfather C and his two siblings. He worked as a process worker, then commenced a diesel mechanic apprenticeship in his stepfather's business. He was a permanent resident of Australia, but did not take steps to become an Australian citizen. He continued to be a citizen of the Philippines.

10. A formed a de facto relationship in 2010 which ended the following year. His de facto partner was the victim of offences committed by A in January 2012, of sexual intercourse without consent and intimidation. On 17 October 2014 A was convicted of these offences and sentenced to a term of imprisonment. He would not be eligible for parole until January 2018.

11. Prior to be being sentenced A had commenced a new de facto relationship with D, and their relationship continued while A was in custody. D visited A weekly and spoke with him most days by phone. A's mother, stepfather, brother and sister were also very regular visitors.

12. At the close of evidence in the inquest, A's mother and his sister spoke movingly of A on behalf of their family. A's mother spoke of his happy personality, his easy nature with people, and his respect for her. She is heart-broken by his death. A's sister described how she had been looking forward to visiting him on the weekend after his death, and her sadness at never seeing her big brother again. It was evident that A was much loved by his family. It grieves them deeply to know that he became overwhelmed with despair at his situation, and died alone.

A's health while in custody

13. A did not have any significant physical health issues. Nor prior to entering custody did he have any reported history of mental health problems. While he was in prison he had various primary health appointments for routine physical health matters.

14. When he was received into custody in October 2014 A had a Reception Screening Assessment. This noted that he had *'denied suicidal, self harm or harm others thoughts'.* The following year A began to experience sleep problems. In November 2015 he referred himself to the prison health centre due to '*feeling stressed'* and having sleep difficulties.

15. The first documented reference to A suffering depression was on 20 June 2018. He had been transferred to the Special Programs Centre at Long Bay Correctional Centre so he could participate in a program for convicted sex offenders, which will be further described below. On arrival at Long Bay Correctional Centre A received a primary health care assessment in which he disclosed that he had been experiencing depression.

16. While assessing A, Registered Nurse Mary O'Gorman noted that he '*can guarantee safety of self and others when asked*'. She referred him for assessment by a mental health nurse, placing him on the waitlist as 'Category 3'. This refers to patients who are considered stable but require attention within 14 days to three months.

17. Two days later, in another attendance at the health clinic A again complained of a lack of sleep due to stress. His place was maintained on the mental health nurse waitlist, and he was advised to speak to a psychologist employed by CSNSW.

18. When A died six months later he had still not been seen by a mental health nurse, despite RN O'Gorman's classification of his clinical need. This failure and its possible impact on A's risk for suicide will be considered later in the findings.

The Moderate Intensity Sex Offender Program

19. While he was in custody A completed various programs including first aid, working safely at heights, and use of calculators. However in January 2018 he was refused parole because he had not undertaken a specific program to address his sex offending behaviour. This was the Moderate Intensity Sex Offender Program [the MISOP program], a custody-based residential therapy program for men who have committed sex offences. The six to eight-month program aims to help men change the thinking, feelings and attitudes which led to their offending behaviour.

20. A decided to undertake the MISOP program and he commenced it on 5 July 2018, choosing not to seek parole in November 2018 so he could complete it. At the time of his death on 20 December 2018 he was very close to completing the program. He would next be eligible for parole on 29 January 2019.

21. The MISOP program and similar ones are conducted in a wing of Long Bay Correctional Centre called the Custody Based Intensive Treatment wing, or CUBIT wing. This is a stand-alone unit housing a small number of offenders, which aims to create a therapeutic community. All inmates in the CUBIT wing are engaged in sex offender therapeutic programs, and are expected to work on treatment goals and practice their new skills together. They have a high degree of access to psychologists, mainly through the program's frequent group sessions. They also have certain freedoms not available to other inmates, in order to assist their transition from custody to the community.

22. Ms Meagan Donaldson facilitated the MISOP group in which A was enrolled. Ms Donaldson is a registered psychologist with endorsement in forensic psychology. She was employed by CSNSW from 2002 until her resignation in 2020. From September 2012 onwards she was a senior psychologist, responsible for managing the teams which provided programs for sexual offenders.

23. Ms Donaldson came to know A well in the course of their group sessions, which were conducted twice weekly and sometimes thrice weekly. At the inquest she described him as '*an active and vocal member from the beginning'*. He attended all group sessions and treatment work, and *'was open to feedback from the therapist and group members'.*

24. At the inquest Ms Donaldson told the court that throughout the course A appeared motivated to address the factors which had led to his offending, and appeared keen to move on with his life. In her statement she described him as '*energetic, good humoured, and appeared to form genuine friendships with others'.*

25. Two such friendships were with fellow inmates R and S. At the inquest R and S gave evidence about A and his state of mind in his last days, which will be described further below.

A's immigration status

26. A significant factor in A's life during his last year was his immigration status. On 27 June 2017 A's permanent resident visa was cancelled due to his criminal convictions. This meant that when his sentence concluded he would be deported to the Philippines. This was a source of distress for him, as he wanted to remain in Australia.

27. A wrote to the Minister for Home Affairs on 14 December 2017, asking that his visa not be cancelled as he had no close family in the Philippines and nowhere to live there. He was not successful: on 13 November 2018 he was notified that the original decision to cancel his visa would not be revoked. According to R and S, A was noticeably stressed and worried by this news.

28. With help from Ms Donaldson, A lodged papers for a merit review of the decision, and a hearing was listed in the Administrative Appeals Tribunal on 21 and 23 January 2019. A's mother thought that he was fairly optimistic of success.

29. A was aware that completion of the MISOP program would be helpful in getting parole. He also believed it would boost his chances of remaining in Australia after his sentence expired. This belief appears to be based on advice provided to A by CSNSW Psychologist Owen Warner in August 2017, and a discussion A had with his mother. In the second of his three statements, A's step father said A had been told that if he completed the course '*he could stay in Australia when he finished it and was released*'.

30. Against this background therefore, the news on 13 November 2018 that his visa would nevertheless be canceled must have left A with strong feelings of disappointment and dismay. A's mother believed that he '*got inconsistent advice and information ...and that gave him a false sense of hope, and made the disappointment and frustration much worse for him'.*

Additional stresses in A's final week

31. In the nine days prior to A's death two things happened which greatly added to his distress.

32. A's partner D was a frequent visitor and they spoke on the phone several times each week. During her visit on 8 December 2018 they talked about his upcoming tribunal hearing, and A told her that on her next visit he would give her some documents to deliver to his lawyer.

33. However in a phone conversation on 11 December 2018 D told A that she no longer loved him and was ending their relationship. A was very upset and said words similar to: '*If we don't end up together, I better end my life'*. D did not consider he was serious about taking his own life. She assured him that she would continue to help him, and indeed they had further phone conversations throughout the week.

34. In one of these conversations A became angry that D had forgotten to book a prison visit to collect the documents for his lawyer. She agreed to visit him again on 22 December 2018 for this purpose.

35. Then on 17 December 2018 the family received sad news from the Philippines: A's uncle had died. A had been very close to his uncle, who had helped his mother to bring him up. On 18 December 2018 D broke the news to A on the phone, describing him as '*speechless*' when she told him.

A's emotional condition in his last weeks

36. Corresponding with these sad events, in A's final couple of weeks a number of people grew concerned about his state of mind.

37. One of these was A's stepfather C. C spoke with A on the phone fairly regularly, and around this time he noted a significant shift in A's mood. In their telephone calls A was crying and seemed to be '*scared of something or mentally broken … his attitude was 'I don't care anymore*', *he'd say that sometimes'*.

38. C was deeply concerned about A. In his second and third statements and in his evidence to the court, C said that he had rung the correctional centre on two occasions to convey how worried he was that A might hurt himself. C does not believe that any action was taken after his calls. I will discuss this evidence later in the findings.

39. Fellow inmates also noticed A's deteriorating mood. A number of them provided statements to the inquest, describing A as a generally happy and energetic person who got on well with everyone. This changed in his last couple of weeks. R, who was sharing a cell with A at the time, said that in his last days A seemed '*mentally and emotionally drained and was giving up on everything'.* S thought he had become isolated and '*withdrawn, depressed,*

sluggish and definitely not his happy self'. R and S did their best to support A when he received the news of his immigration status and the break-up with D.

40. In his final week A made a number of allusions to taking his own life. On 14 December 2018 he was seen to be crying in a phone conversation with D. The next day he said to her:

> *'I feel my life is nothing …If I lose you, I would rather die …I want to finish my suffering.'*

Three days later he told her:

> *'You might not see me this Saturday, as what I've said before, my life is nothing if I don't have you'.*

41. That day in his group session A told Ms Donaldson and the group members that his relationship with D had ended. He informed his cell mate R that he wasn't going to the gym anymore and *'did not have faith in God anymore'.*

42. The next day A learnt of the death of his uncle. The following evening, 19 December, he told R that he was worn out, saying *'I'm so tired, I can't get out of it'.* It was on the next morning that he took his life.

20 December 2018

43. On the morning of 20 December 2018 A was observed during a routine head check at 6.15am. Soon afterwards R left their cell to go to the gym, returning at 7.20am. On the door of their cell he saw a sign indicating '*do not disturb'*. Knowing A had been feeling low, and thinking that he might want to have some time to himself, R left to have breakfast.

44. R came back at 8.00am and saw that a green towel had been placed across the inside of the cell door window. The cell door had been locked from the inside, but R had a key and used it to enter. He immediately saw A hanging from the cell ceiling. R rushed outside and shouted for help, then returned and tried to hold A up from the waist. Other inmates ran to help him, while a correctional officer cut the noose that was suspending A from a conduit pipe in the ceiling.

45. A was carried outside his cell and correctional officers commenced CPR, while an inmate conducted mouth to mouth breathing. A medical team arrived and attempted to use a defibrillator, but A could not be revived. He was declared deceased at 8.11am.

The issues at the inquest

<u>The adequacy of A's mental health care and treatment</u>

46. The inquest examined two key aspects of A's mental health care and treatment while he was in custody.

47. The first was why, six months after being placed on the waitlist, A had not been reviewed by a mental health nurse. The second issue was the question whether, in light of her interactions with A in his last few days, psychologist Ms Donaldson should have made a formal notification that he was at risk of suicide or self-harm.

48. On these questions the court was assisted with evidence from the following witnesses:

- Ms Meagan Donaldson, senior psychologist
- Dr Trevor Ma, Clinical Director of Custodial Mental Health within the JH Network
- Mr Terry Murrell, General Manager of Statewide Operations within CSNSW
- Dr Kerri Eagle, forensic psychiatrist.

49. In addition to giving evidence Dr Kerri Eagle provided a report providing her opinion first, as to whether the overall care and treatment A received while he was in custody was adequate; and secondly, whether Ms Donaldson ought to have notified that he was at risk.

The failure to be seen by a mental health nurse

50. It was common ground that at the time of his death on 20 December 2018 A had still not been seen by a mental health nurse, despite a referral having been made on 20 June 2018.

51. At the inquest Dr Ma was asked about this failure. He explained that at the time of A's death, the Long Bay inmate population of approximately 1,000 was being assisted by the equivalent of a 1.5 fulltime mental nurse position. Official waitlist times could not be met, as appointments had to be postponed due to the need to interpose emergency cases.

52. Dr Ma advised there is now the equivalent of two fulltime mental health nurse positions. This has been achieved not because of additional funding, but by reallocating existing state-wide resources. Dr Ma pointed out that unfortunately this had *not* led to an improvement in the wait time for inmates to see a mental health nurse. In fact the proportion of inmates who had not been seen within the required waiting times had increased. The reason was that the same period had seen an increase in the inmate population, and resources for mental health care had not kept pace with this increase.

53. Dr Ma and Dr Eagle were both asked what treatment a mental health nurse might have provided to A, had he been able to be assessed prior to his death. They concurred that if on presentation he appeared to be suffering an underlying mental disorder or illness, he would likely have been referred to a psychiatrist for treatment options such as medication. This could have reduced A's risk for suicide. Both cautioned however that it was not clear on the material

if A was in fact suffering an underlying disorder. Nor was it possible to say that any such treatment would have prevented his death.

54. On the evidence therefore, it cannot be said that had A been assessed by a mental health nurse this would have prevented his very sad death. However I accept the submission made on behalf of A's family, that seeing a mental health nurse would have offered an additional support for A and may have reduced his risk for taking his own life.

55. The failure to ensure that A was seen by a mental health nurse ought not to go without comment. The submissions on behalf the JH Network pointed to recent steps taken to improve its custodial health services. These appear to consist mainly of enhancements to its information management systems. The improvements will allow the JH Network to better identify those patients whose waitlist times have been exceeded.

56. Without wishing to minimise these steps, I observe that of themselves they are unlikely to ensure that inmates receive the care they need in a timely way. Dr Ma's evidence in his first statement and at the inquest was that A's referral to see a mental health nurse did not take place because '*the demand placed on the mental health waitlist outweighed the available staffing resources in the period'*.

57. The neglect of funding for custodial mental health services has long been a matter for coronial concern. Recent examples include the *Findings of inquest into the death of F*, 11 June 2021, Ryan DSC; and *Findings of inquest into the death of MH*, 15 July 2021, State Coroner Magistrate O'Sullivan. As a society we cannot find it acceptable that men and women who need help are forced to wait so long to receive it. Inmates are not at liberty to arrange their own medical and psychological help and neither are their families. They depend on the State to do so.

58. For this reason I will request those assisting me to forward a copy of the findings in this inquest to the Ministry of Health, for consideration of the issue of funding for mental health services in Long Bay Correctional Centre, with emphasis on funding for mental health nurse positions.

59. I will now consider the second aspect of A's mental health care and treatment. This is Ms Donaldson's interactions with A, and whether these ought to have led her to take a different course of action in relation to his risk of suicide.

Ms Donaldson's interactions with A

60. Senior psychologist Ms Donaldson facilitated the group sessions for A's group. In this role she had additional interactions with A, first in helping him with documentation for his immigration review, and secondly during his last week, discussing with him the breakup of his relationship with D and the death of his uncle.

61. By the time of these events, the participants in A's group sessions numbered three or four. In the group session on 17 December 2018, A told the group that D had ended their relationship. He had not yet become aware of his uncle's death. According to Ms Donaldson's case notes, A was emotional and told the group he felt '*hurt, lost and rejected'*. Part of the 2.5-hour session then focused on helping A to identify his feelings and to develop strategies to cope with them. These included keeping a journal, maintaining a routine, and talking to others.

62. After the group session Ms Donaldson attended a staff meeting in which she informed her colleagues about A's relationship breakdown. The attending staff included both therapeutic and custodial staff.

63. After this Ms Donaldson had a one-on-one meeting with A. She told the court that having an individual session with a program participant was uncommon, as the program primarily used a group-based learning model. Nevertheless she thought it was important on this occasion. A was deeply distressed about his relationship breakup, on top of his longstanding concerns about his immigration status. She wanted to see how he was coping and to consider whether any risk of suicide or self-harm was present.

64. During the individual meeting Ms Donaldson found A to be calmer and less tearful than in the group session. They talked again about coping strategies, and about accommodation options on his release. She reminded him that she needed to be sure that he was safe. To this he replied: '*I wouldn't do that'*. Overall Ms Donaldson felt reassured that A was 'processing' the relationship breakup and had some protective factors in place. These included that he had post release plans, he had friends who were fellow participants in the program, and he had access to a treating psychologist. In her notes Ms Donaldson concluded: *'I did not consider [A] to be at risk of self harm or suicide at this time'.*

65. The next day was 18 December. Ms Donaldson again facilitated the group session. A had just received the sad news of his uncle's death, and he was again emotional and tearful. Ms Donaldson asked if she should be concerned about his safety. A's reply was '*I've thought about it, but it's not worth it, I know how to cope'*. He said further he was '*okay'.*

66. A had mentioned to Ms Donaldson that he would like to have the support of a chaplain, so after the group session she emailed Chaplain Colin Sheehan suggesting that A would benefit from pastoral support. After that she attended a staff and inmate social event. She observed A keeping company with S and then preparing and eating a meal. She thought these were positive signs that he was coping. In her statement she said: *'I had certainly not formed a view that [A] was at risk of hurting himself*'.

67. The following day, 19 December 2018, Ms Donaldson spoke briefly with A to let him know she had contacted the Chaplain. Nothing about his presentation caused her any particular concern. This was the last time she saw him.

The CSNSW policy for mandatory notification

68. Ms Donaldson did not make a mandatory notification that A was at risk of suicide or self-harm. Given the above interactions, ought she to have done so? Notably, in his statement and oral evidence Mr Terry Murrell said that in his opinion Ms Donaldson was required to have made a notification, once A had disclosed on 18 December 2018 that he had '*thought about it'.*

69. The process of raising a mandatory notification is an element within CSNSW policies directed at managing inmates who are at risk of suicide and self-harm. The primary policy is Custodial Operations Policy and Procedures 3.7 [COPP 3.7]. Prevention of suicide and self-harm is stated to be a team responsibility to be shared between staff of CSNSW and the JH Network '*at all staffing levels'*:

70. COPP 3.7 mandates that staff make a notification of risk of self-harm or suicide, in circumstances where they have identified that such a risk is present. A mandatory notification leads to the formation of an Immediate Support Plan for the inmate's health and safety. The plan must be appropriate to the level of risk, and be consistent with the principle of least restrictive care.

71. Within 24 hours of the mandatory notification being made, a Risk Intervention Team must convene to review the inmate's risk and if need be, develop additional strategies to manage it.

72. To guide staff in identifying if an inmate is at risk of suicide or self-harm, COPP 3.7 attaches two key documents:

- Suicide and Self Harm: Risk Factors for Consideration - Reference Guide
- Suicide and Self Harm: Inmate Interview Questions to Further Evaluate Risk.

73. Part 2 of the Policy mandates that both documents '*must be read in conjunction with [COPP 3.7]*'.

74. The first document, which I will call the 'Risk Factors document', directs staff to raise a mandatory notification where an inmate has current or recent suicide or self-harm thoughts or behaviour. In dot point form, five types of such thoughts or behaviour are listed. Relevant to A, the third one is '*Thoughts of suicide, self harm or dying in the last 72 hours'*.

75. The Risk Factors document also directs staff to '*investigate further'* when they become aware that an inmate has, among other things:

- a current mental health impairment (including '*threat of suicide or self harm as 'throw-away line")*
- current or recent situational factors.

76. Mr Murrell told the court that expert advice had guided the content of the Risk Factors document and the Inmate Interview Questions. Their purpose was to give staff as much guidance as possible in identifying and responding to the risk of suicide or self-harm.

77. Mr Murrell explained that the policy and attached documents were intended to provide a low threshold for mandatory notification. This was because all staff members, irrespective of job description or level of training, were responsible for helping to prevent suicide and self-harm. Many staff members would have no training or experience in assessing an inmate's mental health. They may also lack familiarity with the inmate. Nevertheless they had an obligation to apply the policy if they identified that a risk may be present.

Ms Donaldson's evidence concerning mandatory notification

78. In her evidence Ms Donaldson said she was familiar with the content of the above two forms, but she had not had cause to use them while working with the CUBIT programs. In her experience it was uncommon for CUBIT participants to experience acute suicidality. They lived in a minimum security therapeutic environment, and were usually at a stage in their sentence where their release date was approaching.

79. Ms Donaldson told the court that on 18 December 2018 she had concluded that A did not reach the threshold where she needed to make further enquiries, or to undertake a comprehensive risk assessment. She explained that the latter would have involved exploring with A what the 'thought' was, in response to his comment that he had '*thought about it'*. At the time she had concluded that although A had had a '*thought*' it appeared to have been fleeting, and he had discounted it with his follow up comments that '*it'* wasn't worth it and that he knew how to cope. He had then discussed with her his plans to manage his distress. She had concluded from this, that his expression that he had '*thought about it'* did not amount to a thought of suicide or self-harm, such that she needed to make a mandatory notification.

80. Because of these features, Ms Donaldson had formed the view that A was not at risk of suicide or self-harm. However she said that with hindsight, it would have been of benefit to have explored with him what the nature of the thought was, and whether an intent lay behind it.

The submissions on behalf of A's family

81. On behalf of A's family, Ms McLaughlin submitted that Ms Donaldson was obliged to make a mandatory notification following A's comment to her that he had '*thought about it'*. It was submitted that Ms Donaldson's failure to do so was inconsistent with applicable policies, reflecting:

> *'… a fundamental misunderstanding of either or both the content of those policies and procedures – or the level of risk required before a mandatory notification is to be made'*.

82. This submission is based on the argument that pursuant to COPP 3.7, notification is not optional once an event has occurred that falls within any of the three circumstances on the front page of the mandatory notification form. The three circumstances are:

a a deliberate act of self-harm/attempted suicide has occurred
b a threat of self-harm/attempted suicide has occurred
c an inmate is assessed as at risk of self-harm/suicide.

83. The evidence of Mr Murrell, referred to above, provides support to this submission. Mr Murrell said that he interpreted COPP 3.7 strictly; and that Ms Donaldson ought to have made the notification *'… in the strictest sense of the [Policy]'.*

Does the policy permit an element of discretion?

84. I accept the submission that COPP 3.7 and its attached documents remove any discretion to make a mandatory notification, once a staff member identifies the presence of any of the features listed under the heading '*Raise mandatory notification if..*'. In A's case, the factor is said to be the presence of '*Thoughts of suicide, self harm or dying in last 72 hours'*.

85. However I do not accept that Ms Donaldson's decision not to make a mandatory notification in A's case evidenced any misunderstanding on her part, either of the content of the policy or the applicable level of risk.

86. Acceptance that a staff member must raise a mandatory notification once they have identified the presence of a listed risk factor does not mean that there is no room for individual discretion in deciding whether that risk factor is actually present. The Policy, as well as the application of commonsense, dictate that a staff member is to exercise judgement in identifying whether the inmate's thought actually amounted to one of suicide or self-harm.

87. This was the opinion held by Dr Eagle, who commented that an element of clinical judgement was required in ascertaining whether a person presented with any of the listed risk factors. In her view A's remark that he had '*thought about it'* was '*very ambivalent and very vague'*, and there existed a wide range of such expressions. There had to remain room for clinical judgment in interpreting whether a person's expression was in fact a threat of self-harm or suicide.

88. Dr Eagle's evidence on this point is in my view supported by the documentation. The Risk Factors document itself recognises there may be ambiguity in the nature of the inmate's expression. While thoughts of suicide or self-harm require the staff member to raise a mandatory notification, in circumstances where the threat is a *'throw-away line'* the staff member is instructed to '*investigate further'*. The term '*throw-away line'* appears to acknowledge that in some circumstances, an inmate's expression of a thought may require the staff

member to consider whether it does in fact represent a thought of self-harm or suicide, so as to mandate notification.

89. This interpretation is reinforced by 2.1 of COPP 3.7, wherein it is stated that

> *'Any staff member who suspects an inmate might be at risk of suicide or self harm must make further inquiries to determine if a mandatory notification is required …'* [underscore added].

90. I conclude therefore that it is mistaken to interpret the Risk Factors document as removing clinical discretion from the decision to make a mandatory notification. Room must be left for further inquiry as to whether the inmate's expression does in fact amount to a thought of self-harm or suicide. This may particularly be the case where the staff member is, like Ms Donaldson, an experienced psychologist who has worked extensively with the inmate. So much was implicitly acknowledged by Mr Murrell in his evidence, when he conceded that certain factors could bear upon whether the staff member determined that a mandatory notification was required. Two factors which he identified were the mental health expertise of the staff member, and his or her degree of familiarity with the inmate.

91. Having carefully reviewed the evidence, I do not consider it was unjustified for Ms Donaldson to have regarded A's comment that he had '*thought about it'* as an expression in the nature of a throwaway line. A had no history of suicidal behaviour or mental illness. He had followed his comment with further remarks that '*it'* was *'not worth it'* and that he knew how to cope. Furthermore despite the distressing events of his last week, he had continued to actively participate in the MISOP program. At times he showed that he was applying his skills to cope with the impact of these events.

92. The conclusion I reach is that in deciding that she did not need to make a mandatory notification, Ms Donaldson exercised clinical judgement and further, that COPP 3.7 permits her to do so. On the basis of what she knew about A and his situation, it was not unreasonable for her to have concluded that his implicit reference to suicide was in the nature of a throwaway line.

93. That being so however, the appropriate response from Ms Donaldson would have been to '*investigate further'* with A what his thought was and what he meant by it. This response would have been consistent with COPP 3.7 and in particular the Risk Factors document.

94. In this respect I accept Dr Eagle's opinion that while A's statement that he had '*thought about it'* may not have amounted to an expression of self-harm or suicide, it did require further questioning as to what he meant by it. In her view Ms Donaldson ought to have further explored A's remark, ideally in another one-on-one meeting with A after the group meeting on 18 December 2018.

95. I note that in her evidence Ms Donaldson recognised and acknowledged that it would have been appropriate for her to make further enquiry with A on 18 December 2018.

Was Ms Donaldson's management of A consistent with her professional training and expertise?

96. The submissions on behalf of A's family fairly conceded that there is no basis to make an adverse finding against Ms Donaldson on this ground. The submissions acknowledged Dr Eagle's opinion, that the major risk factor which A presented at the time of his death was overwhelming distress caused by the recent events in his life. Ms Donaldson's psychological treatment had been properly focused on helping A to cope with that. It was *'appropriate evidence-based psychological support'.*

97. There is a further reason why it would not be appropriate to be critical of Ms Donaldson in relation to her decisions about A's risk for suicide. This is her lack of awareness of two events which she said would have had a bearing on her approach.

98. The first of these was that A's stepfather had contacted the correctional centre expressing concerns about A's state of mind. Ms Donaldson agreed that concerns held by an inmate's family were important information, and that '*at the least'* she would have raised these concerns with A had she known of them.

99. The second was the fact that in June that year A had been referred for review to a mental health nurse. This may have indicated to Ms Donaldson that A's state of distress was of a more longstanding nature, and had not just developed in response to the events of the past couple of weeks. Relevantly, I note that the Risk Factors document instructs staff to raise a mandatory notification when '*external sources of information suggest threats, thoughts of or an actual suicide or self harm attempt in the last 72 hours'.*

How did A get access to the rope?

100. A second issue for examination at the inquest was how A got access to the rope, or more properly speaking the cord, which he had used to make the noose. This was a matter of significant concern for A's family.

101. In her autopsy report, forensic pathologist Dr Rianie Janse Van Vuuren described the ligature as consisting of '*two strings tied together and folded into a small loop, extending into two loose ends.'*

102. On the ceiling of A's cell was an electrical conduit pipe leading to the ceiling light. It was around this pipe that A had tied the cord which he used that morning. The inquest heard evidence as to where A may have obtained the cord.

103. The correctional officer who first responded to the emergency was Khalil Mesann. He said that he recognised the cord around A's neck as the same type which inmates in the CUBIT wing sometimes used to hang their washing. According to Officer Mesann, correctional officers were aware that the cords were potentially harmful and would remove them; however the inmates seemed to have little difficulty replacing them.

104. When Officer in Charge of the coronial investigation Senior Constable Kimberley Flaskas attended the scene, she noticed cords of similar appearance in different places around the CUBIT unit. She saw a '*white coloured rope'* being used as a clothesline at the entrance to A's wing. In a garden bed outside the cell area she also saw '*a clear/white coloured string'*. She formed the opinion that the cord used by A had been woven using a combination of both types of string.

105. Scene photographs of A's cell were taken immediately after his death. These show an improvised cloth curtain stretching from the end of the double bunk bed to the opposite wall. It was intended to give users some privacy when using the toilet. A's friend and cell mate R told the court that the curtain was attached to a handmade white cord. He was unsure who had first put the curtain up. He added that inmates used the same type of cord to hang washing in the garden.

106. A's friend S had previously shared the same cell with him. S told the court that he and A had put up the toilet curtain, attaching it to a nylon cord which A had made. To make the cord A had woven together pieces of nylon twine which were used to bind the inmates' bed linen when it was delivered to them from the prison laundry each week. S said that in his experience, the correctional officers did not confiscate the handmade lines. Like R and Senior Constable Flaskas, S had also seen similar twine used in the garden.

107. The court heard evidence as to whether any changes had been made since A's death, regarding the inmates' access to rope or cord products.

108. In response to A's death, on 10 March 2021 a Security Direction was issued in relation to laundry bundles at the Metropolitan Special Programs Centre. The Direction prohibits the use of 'plastic rope' for tying linen products from the prison laundry. Short plastic cable ties are now used.

109. This response is welcomed, and obviates the need for me to make a recommendation in relation to this issue.

Hanging points in prisons

110. The manner of A's death also raised issues about the accessibility of hanging points in Long Bay Correctional Centre.

111. Every year inmates in NSW prisons take their own lives in tragic circumstances, often by hanging themselves. Repeatedly, expert evidence in inquests has

emphasised the importance of suicide mitigation strategies, in particular reducing inmates' access to hanging points. Recent examples include the *Findings of Inquest into the death of Tane Chatfield*, 26 August 2020, Grahame DSC; and *Findings of Inquest into the death of L*, 20 April 2019, Ryan DSC.

112. The existence of hanging points within NSW prisons has also been the focus of parliamentary interest, most recently in the following:

- the NSW Legislative Council's *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* conducted in 2020 and 2021
- the NSW Legislative Council's Legal Affairs Committee Budget Estimates sessions of March 2021.

113. In this inquest, psychiatrists Dr Ma and Dr Eagle concurred that it is not possible to predict with reliability if and when a person will complete suicide. Both stated that given this uncertainty, the most effective way to reduce the risk was to minimise access to hanging points.

114. In older correctional centres like Long Bay Correctional Centre where A was incarcerated, the risk posed by hanging points is heightened, as the older design of its fittings and furniture presents greater opportunities for suicide by hanging.

115. For this reason those assisting the inquest sought information from CSNSW as to what steps had been taken since A's death to reduce the prevalence of hanging points in cells at Long Bay Correctional Centre. Assistant Commissioner Leon Taylor provided a statement in response. He is responsible among other things for NSW prison infrastructure planning.

116. Assistant Commissioner Taylor advised that funds of $6 million had recently been made available for projects to improve cell safety in NSW prisons. Cell safety projects focus on:

- building new cells which incorporate anti-ligature design principles
- removing obsolete cells
- refurbishing old cells to remove hanging points.

117. The new funding will be used to reduce hanging points in Long Bay, Parklea and Junee Correctional Centres. At Long Bay Correctional Centre, cells containing a total of 249 beds are in the process of being refurbished to remove obvious hanging points. The work focuses on removing unsafe plumbing fixtures, bed frames and light fittings, and replacing these with safer alternatives.

118. It is encouraging to hear of these efforts to reduce suicide risk in NSW correctional centres. The new funding evidences a recognition by CSNSW authorities of the seriousness of this problem, and a commitment to reduce its magnitude.

119. However the Long Bay refurbishment program will not include cells in the CUBIT wing. In his statement Assistant Commissioner Taylor said that priority for refurbishment funds is given to maximum security prisons which house inmates on remand, and mentally ill inmates. These inmates are considered to be most vulnerable to self-harm or suicide.

120. Assistant Commissioner Taylor explained further that as a minimum security wing, the CUBIT unit is intended to '*recreate a more homely environment encouraging behavioural reform'*. Thus the unit's features and fittings are less austere in design than those in more secure parts of the prison.

121. I accept that it is proper for the Assistant Commissioner to take a risk-based approach to the allocation of resources for suicide mitigation. I also accept that in places like the CUBIT wing a balance needs to be found between safety considerations on the one hand, and on the other, creating an environment to support inmates on their path of adjustment into community life. This is likely to result in a reduced focus on suicide mitigation in the design of furniture and fittings.

122. For this reason it would not be appropriate in this inquest to make a recommendation that has repeatedly been made in previous ones. I will simply make the observation that a large proportion of NSW inmates continue to be housed in environments which present significant self-harm risks. There is a compelling need for NSW authorities to continue the work of reducing this risk by providing accommodation which conforms with safety standards.

123. The remaining areas for examination involved communication issues between custodial agencies and the families of inmates.

Communication between staff of CSNSW and JH Network

124. I have noted that in December 2018 Ms Donaldson was unaware A had been referred for review by a mental health nurse. This was not a failure on her part: there is no evidence that this information was recorded in any documentation available to her. In her evidence Ms Donaldson said this information would have been of benefit to her in understanding the level of A's risk for suicide.

125. For this reason, Counsel for A's family proposed that CSNSW and the JH Network:

> *' …develop the necessary procedures and policies to ensure that referrals for mental health services for inmates are communicated between both agencies, and the fact of that referral and its outcome is recorded on [the Offender Integrated Management System]'.*

126. On behalf of CSNSW it was submitted that the issue of information sharing between CSNSW and JH Network staff is not straightforward. I acknowledge this is the case. There are important privacy reasons why it would not be

appropriate for CSNSW staff to have access to certain JH Network records regarding inmates and their health disclosures.

127. Nevertheless based on the evidence given at inquest by Ms Donaldson and Dr Eagle, there is a case for CSNSW psychologists at least, to have access to key information about an inmate with whom they are working, such as a referral within the JH Network for an inmate to see a mental health nurse.

128. In his evidence, Dr Ma said that work was underway within the JH Network to allow CSNSW psychologists access to relevant JH Network records. Discussions and planning had commenced in April 2020. For this reason, it was submitted on behalf of the JH Network that there was no need for the recommendation sought by A's family.

129. However I have decided to make a recommendation along the lines sought by A's family. I intend no criticism of Dr Ma, when I say that his evidence on this project lacked the detail I would require in order to be satisfied that this issue had been addressed. I will therefore make a recommendation as follows:

> *'That CSNSW and the JH Network develop the necessary procedures and policies to ensure that referrals made by the JH Network for mental health services for inmates and the outcome of those referrals be communicated to CSNSW psychologists'.*

Communication between families and correctional centres

130. Adding to their grief at the loss of their son, A's mother and stepfather are distressed that CSNSW authorities appear to have taken no action in response to calls which C said he had made during A's final weeks.

131. C's evidence is that he rang the correctional centre twice in the weeks leading up to A's death. In both calls he expressed his deep concern that A was '*at rock bottom'* and would harm himself. He said that someone needed to '*keep an eye on A'.* C says that on both occasions the person to whom he spoke said they would pass the information on.

132. As noted, Ms Donaldson was unaware that A's family were deeply worried about his emotional state during his final two weeks. She and Dr Eagle concurred that serious concerns held by A's family would have been important information for Ms Donaldson to know when considering his risk level.

133. According to submissions made on behalf of CSNSW, I ought not to accept C's evidence that he made the calls. It was submitted that C was, at the least, mistaken about having done so.

134. In her submissions, Special Counsel for CSNSW pointed to discrepancies in C's evidence about the calls, including when exactly they were made. I accept there were areas of confusion in C's evidence about this.

135. The further submission is made that accepting C's evidence that he made the calls would be contrary to '*compelling inferences available'* from police and CSNSW evidence that the calls were not made at all. The evidence relied upon is that NSW Police officers recently searched phone records but were not able to locate any calls made by C to the correctional centre.

136. However the court heard that the searches were unable to encompass a second landline number which C had at the time, but whose number he could no longer recall. In my view this evidence does not support a *compelling* inference that the calls were never made.

137. The further submission is made that C's evidence about having made the calls was of little probative value because accepting it would be *'tantamount to deciding [the issue] on [C's] demeanour'.* I do not know why the conclusion is drawn that if C's evidence is accepted by the court, it could only be on the basis of C's demeanour. As submitted by Counsel Assisting at paragraph 130 of his submissions, it has not been suggested there was any motive for C to fabricate the evidence of his calls, and it is '*entirely believable'* that he would be deeply worried about A and want to tell prison authorities about it.

138. I do accept the submission on behalf of CSNSW, that it would be a serious matter to conclude that CSNSW employees had received C's calls but failed to act in response to his deep concern about A. Consistent with the principles of *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361, a court would require cogent proof in support of such a serious allegation.

139. Bearing the above considerations in mind, I have concluded that the state of evidence is such that I am not in a position to find whether or not C's calls were received by CSNSW employees. For the purposes of this inquest, it may be argued that such a finding is not strictly necessary. This is because based on the submissions on behalf of CSNSW, the Acting Commissioner does not oppose the recommendation proposed by A's family directed at this issue. This is that CSNSW and the JH Network:

> *'.. develop compatible policies and procedures to ensure that family members of inmates are able to effectively communicate their concerns about the mental health or risk of self harm/suicide of that inmate'*.

140. The evidence at inquest provides a basis for a recommendation that CSNSW and the JH Network review their policies and procedures in this area. The court heard evidence that when inmates enter custody, they and their families receive a handbook providing information about how to contact authorities with concerns about the inmate. Yet in their evidence, A's stepfather and A's cell mate and friend R did not recall receiving this. Nor did they appear to be aware of the 1800 hotline operated by mental health nurses on a 24-hour basis, which inmates and families may contact with mental health concerns.

Additional recommendations

141. As noted above, I intend to make recommendations directed at the sharing of certain health information between staff of CSNSW and the JH Network; and that CSNSW and the JH Network review their policies regarding communication with families of inmates.

142. On behalf of A's family it was further submitted that a recommendation should be made *mandating* training in the provisions of COPP 3.7 for all CSNSW employees who come into contact with inmates. In response the Acting Commissioner has advised that he intends to amend 2.1 of COPP 3.7 in accordance with this recommendation. This obviates the need for me to make this recommendation.

143. One further area remains for consideration. This is the question whether COPP 3.7 and its attached Risk Factors document and Inmate Interview Questions require review.

144. In her evidence Dr Eagle said that in her opinion the 'mandatory notification' approach taken in COPP 3.7 was not an effective one for managing risk, and that an individualised assessment was to be preferred. I am confident that the latter approach makes sense in circumstances where the staff member holding concerns about an inmate is a professional mental health practitioner like Ms Donaldson. However where the staff member has no such expertise and experience, there is force in Mr Murrell's evidence that a simple approach is required, imposing a low threshold for notification.

145. Relatedly, Counsel for A's family has submitted that the Risk Factors document ought to include the further risk factor, as to whether the inmate is housed in an area of the prison where the removal of hanging points has not yet taken place. In her evidence Dr Eagle agreed that the inmate's environment and access to lethal means of suicide should be included in the risk assessment. She cautioned however that responding by placing an inmate in a safe cell has associated harms, which may heighten their sense of isolation and remove their access to usual coping mechanisms.

146. In response to the above evidence, Counsel Assisting proposes a recommendation that CSNSW consider reviewing COPP 3.7 and its attachments, in order to:

- determine whether the Policy should apply to psychologists and other professional mental health practitioners employed by CSNSW; and
- determine whether the matters referred to in the Risk Factors document and Inmate Interview Questions documents currently meet the criteria for best practice to prevent suicide or self-harm of inmates.

147. Counsel for CSNSW has advised that the Acting Commissioner does not oppose the above recommendations, and does not oppose a further one to the

effect that an additional risk factor be listed, namely the potential risk for self-harm posed by the inmate's current accommodation.

148. I will make these recommendations.

Conclusion

149. I will close by expressing my sincere sympathy to A's family, and to all others who knew and loved him. I hope that this inquest has answered some of their questions about his sad death.

150. I wish also to thank Counsel Assisting the inquest, the representatives of the interested parties, and the Officer in Charge of the coronial investigation, for their valuable assistance in the matter.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is A.

Date of death:
A died on 20 December 2018.

Place of death:
A died at Long Bay Correctional Centre, Matraville NSW 2036.

Cause of death:
The cause of A's death is hanging.

Manner of death:
A died when he hanged himself while in lawful custody, with the intention of ending his life.

Recommendations pursuant to section 82

To the Acting Commissioner of Corrective Services (NSW):

1. That consideration be given to reviewing Custodial Operations Policy and Procedures 3.7, including annexures 'Risk Factors for Consideration - Reference Guide' and 'Inmate Interview Questions' to:

- determine whether the Policy should apply to psychologists and other professional mental health practitioners employed by CSNSW; and
- determine whether the matters referred to in the Risk Factors and Inmate Interview Questions documents currently meet the criteria for best practice to prevent suicide or self harm of inmates. This review should also consider whether an additional risk factor be listed, namely the potential risk for self harm posed by the inmate's current accommodation.

<u>To the Acting Commissioner of Corrective Services (NSW), and to the CEO, Justice Health and Custodial Mental Health Network:</u>

1. That CSNSW and the JH Network develop the necessary procedures and policies, to ensure that referrals made by the JH Network for mental health services for inmates and the outcome of those referrals be communicated to CSNSW psychologists.

2. That CSNSW and the JH Network develop compatible policies and procedures, to ensure that family members of inmates are able to effectively communicate their concerns about the mental health or risk of self-harm/suicide of that inmate.

I request those assisting me to forward a copy of these findings to the Ministry of Health, for consideration of the issue of funding for mental health services in Long Bay Correctional Centre, with emphasis on funding for mental health nurse positions.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

Date 22 October 2021