CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of F
Hearing dates:	6 – 9 April 2021
Date of findings:	11 June 2021
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest - death of a person in custody – cause of death hanging – adequacy of care provided by the Justice Health and Forensic Mental Health Network - adequacy of custodial mental health care for inmates with severe and chronic mental illness.
File number:	2017/157550
Representation:	Counsel Assisting the inquest: C Melis of Counsel i/b NSW Crown Solicitor. Justice Health and Forensic Mental Health Network: B Bradley of Counsel i/b Makinson d'Apice Lawyers. Commissioner, Corrective Services NSW: M Barnett of Counsel i/b NSW Department of Communities and Justice (Legal). Dr J O'Dea: K Kumar of Counsel i/b MDA National. RN M Harris: K Doust of NSW Nurses and Midwives Association.

Findings:	**Identity** The person who died is [redacted]. **Date of death**: [redacted] died between 24 and 25 May 2017. **Place of death**: [redacted] died at Goulburn Correctional Centre, Goulburn NSW. **Cause of death:** [redacted] died as a result of hanging. **Manner of death:** [redacted] death was an intentional self inflicted death, at a time when he was a sentenced prisoner at Goulburn Correctional Centre.
Recommendations:	**To the CEO, Justice Health and Forensic Mental Health Network:** 1. That the Justice Health and Forensic Mental Health Network [the JH Network] use these findings to advance the position before the NSW Ministry of Health that the "renewed model of care" [redacted] be implemented in consultation with Corrective Services NSW [CS(NSW)]. 2. That in relation to patients approved for unsupervised medication, consideration be given to developing a guideline outlining that any alteration to the patient's medication regime in relation to antipsychotic and antidepressant medication be approved by the patient's treating psychiatrist. An alteration includes any modification to the type, dosage or frequency of medication, including any shift from daily to monthly dispensing. Such guideline should be disseminated to JH Network staff and Visiting Medical Officers and incorporated in relevant induction and annual training.

Non-Publication Orders

Orders prohibiting publication of certain material pursuant to section 75(2)(b) of the *Coroners Act* 2009 (NSW) [the Act] have been made in this inquest. In accordance with those orders, the names of the deceased and members of his family have been anonymised.

Orders have also been made pursuant to section 74 and section 65(4) of the Act over certain evidence.

Copies of the orders can be found on the Registry file.

Introduction

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 F.

3. F was aged 49 years when he died by hanging in his prison cell, sometime between 24 and 25 May 2017. At the time of his death F was a sentenced inmate of Goulburn Correctional Facility. He had been in prison for almost sixteen years.

4. An inquest into the circumstances of F's death is mandatory. This is because as an inmate, F relied on authorities to provide an adequate level of care for his health and welfare. In these circumstances an inquest is required to determine whether authorities have discharged their duty.

The focus of the inquest

5. There was no issue as to the medical cause of F's death. An autopsy report prepared by pathologist Dr Kendall Bailey found that F died as a result of hanging. Dr Bailey's report also noted the presence in F's post mortem blood of a high level of the antipsychotic medication olanzapine.

6. The focus of the inquest was on the manner of F's death. The inquest sought to understand the circumstances which led him to take his own life, and whether the care and treatment he received in custody for his severe mental illness was adequate.

7. Throughout the many years of his incarceration, F was chronically and severely unwell with schizoaffective disorder. He had a consistently high risk for suicide. His mental illness was complex, and this was well understood by those who treated him in custody. It is fair to say that even had he been living in the community, F's illness would have presented very significant challenges for his clinicians.

8. The central issue at the inquest was whether an inmate such as F, with severe and chronic mental illness, can receive adequate care in a prison environment. The evidence which emerged strongly at the inquest was that the existing model of custodial health services is *not* able to meet the needs of such prisoners.

9. In this inquest the court was assisted by expert psychiatric evidence from:

    - Dr Kerri Eagle, consultant forensic psychiatrist and staff specialist with Sydney Local Health District (Mental Health). Dr Eagle's experience includes working as staff specialist psychiatrist at the Forensic Hospital, Malabar NSW.

- Dr Danny Sullivan, forensic psychiatrist and Executive Director of Clinical Services at the Victorian Institute of Forensic Mental Health. Dr Sullivan has many years' clinical experience working in prisons and forensic hospitals.

10. In addition the court received assistance from the evidence of:

    - F's treating psychiatrist for many years, Dr Jeremy O'Dea. Dr O'Dea has provided psychiatric services to prisoners since 1993

    - Dr Sarah Jane Spencer, forensic psychiatrist and the Clinical Director of Custodial Mental Health. Custodial Mental Health [CMH] is the specialty service within the JH Network which provides mental health services to NSW prisoners.

11. Dr O'Dea's and Dr Spencer's many years' experience providing mental health care in NSW correctional centres lends significant weight to the evidence they gave at the inquest.

F's life

12. F was born on 4 April 1968 at North Sydney and he had a sister M. By the time he entered custody at the age of 33 his relationships with his family were very complicated. Nevertheless, it is apparent that his sister M cared about him and she attended each day of the inquest. In addition, F's mother maintained close contact with him throughout his life in prison, initially with prison visits and in his later years by telephone.

13. When he was a child of ten years, F's young life was altered tragically and forever. He and other children suffered sexual abuse at the hands of a gymnastics teacher. The offender faced trial and was convicted, with the help of F's evidence. However, F's sister said he never recovered from these terrible experiences.

14. In his late teens F became socially isolated and began to show signs of psychiatric illness. He attempted to take his own life when he was nineteen and was admitted to hospital, where it was thought he may be suffering schizophrenia. He tried to take his own life again in 1987 and in 1992.

15. In the opinion of forensic psychiatrist Dr Kerri Eagle, F was by this time suffering severe mental illness. She opined that in retrospect it was likely to be schizoaffective disorder with bipolar characteristics.

16. F met his wife MC in 1993 and they had their first child, a daughter. After their marriage in 1995 they had two further children. The couple separated in 1997 and for some time they maintained a flexible parenting arrangement.

17. MC commenced a new relationship around July 2001. This angered F and he tried to persuade her to end it. This was the prelude to the terrible events which took place the following month.

18. Over the weekend of 17-19 August 2001 F was to have the care of the three children, now aged 7, 5 and 4. Sometime between 18 and 19 August he killed his children, using sleeping tablets to sedate them and then drowning them in the bath. He was discovered in the home consuming a milky substance, apparently with the intention of ending his own life.

19. F was charged with the murder of his children. The Crown did not accept his offer to plead guilty to manslaughter on the grounds of substantial mental impairment. Following a jury trial F was convicted of three counts of murder. On 13 February 2004 he was sentenced to imprisonment and would not be eligible for parole until 20 August 2028.

F's psychiatric history in custody, 2001 to 2010

20. F entered custody on 21 August 2001 and received an initial screening assessment. Over the years the diagnoses of his treating psychiatrists varied, but without exception they assessed that he had a very high risk of self harm and suicide.

21. From 2003 onwards F's treating psychiatrist in prison was Dr Jeremy O'Dea, who came to develop a good understanding of F and his complex mental condition.

22. F told his clinicians that he wanted to die and was thinking about it constantly. This and other behaviours led to him being periodically admitted to acute mental health units within the NSW prison system. The antipscyhotic drug olanzapine was added to his medication regime in 2003.

23. On 1 March 2005 while in Goulburn Correctional Centre [GCC] F tried to hang himself using a bed sheet which he had tied to the window bars of his cell. He was transferred to the JH Network's Acute Crisis Management Unit in Sydney's Long Bay Prison for treatment and stabilisation.

24. Of note, the Acute Crisis Management Unit assessed F as at high chronic risk of self harm. They considered it likely his acute risk would fluctuate depending on circumstances, but that his long term risk was unlikely to dissipate. On F's discharge his clinicians made recommendations for the management of his suicide risk, including being placed in a shared cell. F was then transferred back to GCC.

25. In 2007 it became apparent that F was not taking his olanzapine. This behaviour recurred many times throughout his incarceration, and frequently led to relapse of his schizoaffective illness. Over the next three years he had seven admissions to the Mental Health Screening Unit and Long Bay Hospital's Mental Health Unit. These were for management of relapse of his mental illness, paranoia, bizarre behaviour and risk of self harm and suicide. He was prescribed various mood stabiliser and antipsychotic medications.

26. On many occasions F strongly expressed to his clinicians that he wanted to be housed in a cell on his own. He was persistently anxious about interacting with fellow inmates and being asked about the nature of his offences. For the most part he wished to be left alone. In May 2007 his request for a one out cell was refused by his treating psychiatrist Dr Jeremy O'Dea.

27. In November 2009 F attempted suicide again. Once again he tried to hang himself using one of his bed sheets. Of note, it was also found that he had been storing his antipsychotic medication for several weeks.

28. F had another admission to the Mental Health Screening Unit, then returned to GCC on 4 January 2010. For the most part he remained there until his death seven years later.

F's psychiatric history in custody, 2010 to 2017

29. Over the following years F had further periods in which he refused to take his antipsychotic medication. These episodes were generally followed by relapse of his schizoaffective disorder. He continued to request single cell accommodation.

30. Of significance is an observation about F which Dr O'Dea documented on 2 March 2011, that:

    '…longer term management in secure psychiatric hospital [is] likely to be more appropriate than prison'.

31. This issue is a very significant one in the inquest and will be examined later in these findings.

32. In the two to three years prior to his death, F's nursing and psychiatric reviews became much less frequent. He was reviewed by Dr O'Dea in August 2015 and again in December 2015, with Dr O'Dea recording that he was showing some signs of stabilisation. At the latter review Dr O'Dea decided that F could be trialed on unsupervised medication, albeit with '*close monitoring'.* This meant that when F received his daily medication from JH Network staff, he was no longer required to ingest it under their supervision.

33. Despite Dr O'Dea's recommendation for close monitoring, this did not take place. Moreover, in 2016 F did not have any psychiatric reviews, and was seen just once by a JH Network nurse. The following year on 16 February 2017 F was reviewed by mental health nurse clinician Michael Harris. On his recommendation F was moved into a one out cell. The appropriateness of this decision is discussed later in these findings.

34. F's final interaction with the JH Network was a telehealth review with Dr O'Dea on 26 April 2017, four weeks before his death. Dr O'Dea recorded:

    'Impression: schizoaffective disorder remains under adequate if not optimum control and set to make full remission'.

35. He documented a plan to increase F's dosage of olanzapine and to '*continue current treatment with metabolic monitoring'.*

36. In fact the last time F received metabolic monitoring was in 2012. At the inquest Dr O'Dea explained that metabolic monitoring is an important element in the care of patients with schizoaffective disorders. As a result of lifestyle factors and medication side effects they require regular monitoring for weight gain, cholesterol and insulin levels.

F's final days

37. During May 2017 F spoke regularly on the phone with his mother, who was unwell.

38. At about 2.45pm on 24 May 2017 F was locked in his cell, in accordance with usual routine. The next morning at 8.30am a correctional officer opened F's cell door to find him hanging from the cell's window bars. He had again fashioned a ligature from his bed sheet. He appeared to have accessed the cell window by climbing onto the toilet seat below it.

39. Other correctional officers responded immediately and lowered F to the ground. He was unresponsive. JH Network staff arrived and found him pulseless and unable to be revived by CPR or defibrillator. Ambulance officers pronounced him deceased at 8.47am.

40. I will now examine the issues at the inquest.

The nature of F's mental illness

41. From their review of F's medical records, Dr Eagle and Dr Sullivan were both of the opinion that F suffered from schizoaffective disorder, bipolar type, and had likely suffered this condition since early adolescence. In her report Dr Eagle noted F's tragic background of childhood sexual abuse. She thought it probable this had given rise to early difficulties with self esteem and interpersonal relationships.

42. Dr Eagle and Dr Sullivan agreed further that F was at chronic high risk of suicide for the entire period of his incarceration. They concurred that it was extremely challenging to manage such a patient where he or she is serving a long sentence of imprisonment.

43. F's treating psychiatrist Dr Jeremy O'Dea readily agreed with these conclusions. In his first statement he said:

> *'I considered [F] to have a severe psychiatric illness and that … he presented a significant long term risk of suicide. I believe this was borne out in my clinical notes and was indeed a recognised problem in the context of his multiple suicide attempts, non compliance with medication and relapsing condition'*.

What was the appropriate treatment for F?

44. In her report Dr Eagle described schizoaffective illness as:

'…a severe mental illness requiring responsive and coordinated individualised mental health treatment.'

45. In her opinion, given the complexity of his illness F required case management involving:

- regular clinical monitoring of his mental state and early warning signs of deterioration and relapse
- regular reviews by a psychiatrist or psychiatrist registrar
- prescription of antipsychotic medication, and psychiatric reviews to monitor for response to treatment, compliance, and side effects
- development of a plan for relapse prevention, risk management and recovery
- collaboration between different stakeholders involved in his care.

46. Dr Danny Sullivan agreed that F needed a comprehensive and coordinated approach which incorporated these elements. Significantly however, he did not consider that such a treatment plan was feasible within the custodial environment.

47. Dr Sullivan did however agree that in the last few years of his life F did not receive adequate nursing and psychiatric reviews. These were not frequent enough to enable an assessment of the stability of his mental health. In her report Dr Eagle had described the reviews as '*of varying frequency*' and:

'… largely reactive to the stability of F's mental state and behaviour, rather than providing regular monitoring of his mental state and compliance… [They] did not appear to be determined with reference to any overall treatment or management plan or for the purpose of monitoring specific early warning signs of relapse'.

48. Dr Sullivan concurred, characterising F's reviews as '*of high quality and consistency of clinicians, but low frequency*'.

49. It is notable that at the inquest, both Dr O'Dea and Dr Spencer agreed that the frequency of F's nursing and psychiatric reviews was neither adequate nor appropriate. The unanimity of expert evidence on this issue provides a strong basis for me to make this finding.

50. Notably, the four psychiatrist witnesses were likewise unanimous, that mental health services within the custodial setting could not provide adequate treatment for F's severe illness. I will return to this issue later in these findings.

Should F have been placed in a one out cell?

51. On the face of it, the decision to place F in a one out cell does not appear to represent good management of his high risk for suicide. JH Network policy recognises that placement with a cell mate can be a protective factor against self harm, and can facilitate an early emergency response. On previous occasions F's cell mates had notified correctional officers when he attempted self harm.

52. However, Dr Eagle acknowledged that there are competing factors in managing suicide risk by way of cell placement. This opinion was endorsed by Dr Sullivan, Dr O'Dea and Dr Spencer, all of whom have extensive experience treating inmates with a high risk of suicide.

53. While placement in a two out cell can mitigate against risk for suicide, this must be balanced against the risk of harm to the inmate or his cell mate. F found the experience of sharing a cell very distressing and had on more than one occasion voiced thoughts of harming his cell mate. For his part Dr O'Dea, who knew F well, considered that F himself was at risk of harm from cell mates, due to his high levels of agitation and anxiety.

54. I acknowledge that in F's case a decision about cell placement cannot have been a straightforward one. The consensus of expert evidence on this issue does not provide a basis to be critical of the decision to place him in a one out cell, despite his risk for suicide.

Was the management of F's medication regime adequate?

55. This issue was of significance to the inquest for two reasons. First, for certain periods while in custody F was not compliant with his olanzapine. These periods often precipitated relapses of his illness. Secondly, he was known to hoard his olanzapine and had on at least one prior occasion overdosed on his supplies. The evidence supports an inference that in the weeks prior to his death F had again been stockpiling his doses of olanzapine, sufficient to produce the fatal level found in his blood post mortem.

56. This evidence raised concerns about the appropriateness of the decision, in December 2015, that F could be trialled on unsupervised medication, and the further decision on 4 March 2017 that his medication could be dispensed to him in monthly rather than daily batches. Given F's history, the risks inherent in such decisions are evident.

57. According to the medical records, on 15 December 2015 Dr O'Dea determined that F could be trialled on unsupervised medications. This meant that F would be permitted to ingest his daily allotment of olanzapine in his own time. Dr

O'Dea recorded that staff were to '*continue to monitor closely with regular review'.*

58. Dr O'Dea and Dr Sullivan noted that olanzapine has a significant sedative effect. Supervised medication orders require that inmates receive and ingest their medication within dispensing hours. Providing it on an unsupervised basis permits the inmate to ingest it at a more suitable time, usually before going to bed.

59. At the inquest Dr O'Dea said that this decision appeared reasonable to him, as in recent times F had been compliant with his medication. However, while this may have been the case, the decision was problematical in circumstances where, despite Dr O'Dea's direction that F be monitored for compliance, this did not take place.

60. The further plan that F could receive his olanzapine in monthly batches appears to have developed after RN Michael Harris discussed it with F on 16 February 2017. A Self Medication Risk Assessment was performed by visiting GP Dr Scott on 4 March 2017, following which Dr Scott approved the plan. It does not appear that F's treating psychiatrist Dr O'Dea was consulted about this decision, or was aware of it.

61. At the inquest Dr Spencer expressed the view that medication decisions of this kind should be approved by the doctor who best knew the patient, and that this would ordinarily be the treating psychiatrist. This also was the view expressed by Dr Eagle and Dr Sullivan. In the present case, it is evident that this ought to have been Dr O'Dea. Dr Sullivan added that in F's case the decision may not have been inappropriate, provided that F was monitored to ensure that he remained compliant. As we have seen, this did not happen.

62. In circumstances where medication monitoring of F either did not or could not take place, I conclude that the decision that he receive his medication in monthly batches was not an appropriate one. Nor was it appropriate for this decision to be made by clinicians who lacked the familiarity with F that Dr O'Dea had developed. In making this finding I express no criticism of F's individual clinicians. They breached no policies or procedures in making this decision. The shortfall was a systemic one, about which I will make a recommendation at the end of these findings.

63. F's history of medication non compliance and previous overdose attempt in 2009 raised the further question, whether his clinicians ought to have considered administering his olanzapine via monthly injections. This mode of delivery would have mitigated the risks of non compliance and hoarding.

64. The evidence at inquest showed that Dr O'Dea had given careful thought to this course of action, and had made a reasonable decision against it. He explained that safe delivery of olanzapine via monthly injection is problematical within prisons, as it requires a 3-4 hour period post administration to monitor for its potential side effect of collapse. Should the patient collapse, there could no be

guarantee within a prison of speedy emergency help within a prison. I note Dr Sullivan also highlighted this difficulty when asked about it in his evidence.

65. Dr O'Dea added that in F's case he had also considered the option of injecting alternative antipsychotics which did not carry this particular risk. However in his opinion none were suitable for F due to their known side effects of increasing agitation.

66. On the basis of the above evidence, I accept there could not be any criticism of the JH Network or of Dr O'Dea, in deciding that monthly medication injections were not a suitable option for F.

Was a custodial environment capable of providing adequate care for F?

67. I turn now to an issue which was central to the circumstances of F's death, namely whether his complex mental health needs could adequately be met within a custodial environment.

68. At the inquest the court heard evidence about this from both the psychiatrist experts, and also from Dr O'Dea and Dr Sarah Jane Spencer. All were of the opinion that due to its severity, F's mental illness could not be adequately managed within a prison setting.

69. I will first outline the evidence heard at inquest about the manner in which custodial mental health care was provided at the time of F's incarceration. The court heard that there have not been any changes of substance since then.

70. The JH Network provides health and psychiatric services to most of NSW's inmates, who according to figures from the Bureau of Crime Statistics and Research NSW, currently number more than 13,000. Visiting psychiatrists are employed to assess and diagnose inmates' mental illnesses and to prescribe medication. Nurses are also employed to review patients and dispense medication. Psychological services on the other hand are mostly provided by psychologists employed by CS(NSW).

71. The Custodial Mental Health Service [CMH] is the specialist service operating within the JH Network to provide the above services to NSW inmates. It applies a '*hub and spoke*' design. According to this model, specialist mental health facilities provide additional treatment to that provided within the inmate's jail of classification. Most of these specialist services are located in Sydney. Notably, all are for short stay only.

72. The court heard from Dr Spencer that CMH specialist services for male inmates comprise:

- the Mental Health Screening Unit (MHSU), a 43 bed mental health unit to assess and manage inmates who are acutely ill, and those with who combine a mental illness with high suicide risk

- Darcy Places of Detention, with 110 beds for inmates at acute risk for suicide or self harm

- Hampden Places of Detention, a 'step down' unit for up to 138 inmates who no longer need intensive care but are not sufficiently recovered to return to their jail of classification

- the Acute Crisis Management Unit at Long Bay Prison Complex. This has 8-10 beds and is for inmates being managed under a safety protocol, but who cannot be managed within their jail of classification

- The Long Bay Prison Hospital, located within the Long Bay Correctional complex, which has a 40 bed mental health unit for involuntary treatment.

73. The '*spokes'* of the CMH model are located at 17 correctional centres, including GCC.

74. As noted, none of the specialist units is able to accommodate inmates on a long term basis, due largely to the very high demand for their services. This raises the question, what is available for a patient like F, whose severe and enduring mental illness required long term monitoring and review?

75. At the inquest the court heard evidence about this from the four psychiatrist witnesses. All agreed that under the current model, there did not exist any long term option which could adequately manage F's complex condition.

76. Dr O'Dea explained that a patient like F required long term hospital care, to treat his acute phases and to monitor him through his remissions. In his opinion, with which the other three witnesses agreed, services within prison could not provide this kind of care, for the following reasons:

- custodial mental health resources are very stretched. GCC was typical in that it was resourced to provide only a limited number of psychiatric and nursing clinic hours each month. Care of patients needing long term review was compromised, due to the constant need to prioritise new inmates and patients in relapse or acute phase

- prisons severely restrict the availability of health care for inmates, due to the limited hours they permit inmates to attend appointments. These hours are further disrupted by unscheduled lock downs

- a prison is essentially a punitive environment which imposes significant stress upon inmates, exacerbating the condition of those who are severely mentally ill

- a prison can provide only a very restricted range of treatment options. These are usually limited to prescribing medication and reviewing it. This leaves no room for other elements important for the treatment of schizophrenia, including medication supervision, psychosocial treatment, and social support.

77. In short, the degree of monitoring which F needed made him unsuitable for treatment within a custodial environment. Yet as Dr O'Dea noted, his status as a sentenced prisoner within the NSW correctional system made him ineligible for any other type of long term placement, such as a secure psychiatric hospital.

78. The unanimity of expert agreement on this issue was compelling. I reproduce below a sample of the views expressed by the four psychiatrist witnesses, in their reports and oral evidence.

79. In his first statement Dr O'Dea commented:

'Whilst a general tenet of forensic psychiatry is that offenders with severe psychiatric illness are more appropriately and effectively treated in secure psychiatric facilities independent of Correctional Centres, this option was not practically available for [F] …… the long term management of suicide risk, even if high as in [F]'s case, remains a problematic endeavor in Correctional Centres'.

80. In a supplementary statement he added:

'… *[F] was someone who was not suitable to be managed in a correctional centre. Unfortunately there was no alternative accommodation, such as a long stay psychiatric facility for sentenced inmates in NSW which could accommodate [F]. This remains the case today.'*

81. Dr Spencer was of the same view. Her opinion carries significant weight, not only because of her extensive qualifications but significantly, by reason of her role as Director of CMH services in NSW. In a supplementary statement he stated:

'The environment within which custodial patients are accommodated is counter therapeutic: patients are locked in their cells for more than 16 hours a day and their autonomy is severely limited. However this is the environment within which [the JH Network] provides its mental health service'.

82. In his report Dr Sullivan expressed a similar view:

'It is noted [F] was treated in mental health settings in prison rather than being treated in mental health hospitals …mental health treatment provided in prison is unlikely to have the same therapeutic benefit as treatment in a secure and specialised non-prison healthcare setting'.

83. Dr Spencer contrasted this with the model of care provided in the Forensic Hospital at Malabar, which cares for persons who have been found not criminally responsible for their acts due to their mental illnesses. In her supplementary report she said:

'The Forensic Hospital is under the control of NSW Health and both security and health services are provided by [the JH Network] inside the walls of the

Forensic Hospital. As a result, [the JH Network] can implement and administer a health-based model.'

84. In the same statement she provided this striking statistic:

'…There are approximately the same number of equivalent forensic psychiatrists to provide care for the 135 patients in the Forensic Hospital, as there are to cover the 12,000 inmates in the public run correctional centres.'

How did the limitations on mental health resources affect F's care?

85. The answer to this question may appear self explanatory, but it was enlightening to hear from Dr O'Dea how resource limitations impacted on his ability to care for F, and for other patients like him.

86. At the time of F's death, Dr O'Dea was employed to provide only eight psychiatric clinic days over a three month period within GCC. Dr Spencer provided an additional half day clinic each week delivered via telehealth. According to Dr O'Dea, the bulk of this time had to be given to the assessment of new patients, or of patients who had relapsed into acute illness. As he described it at the inquest:

'*Eighty to ninety percent of my patients need to be seen within the next few weeks. They are very unwell'*.

87. Dr O'Dea also had to work around the routines of a correctional setting. In practical terms this meant that patients could be accessed for at most four hours within the day, even without the stoppages of unscheduled lock downs.

88. Dr Spencer's oral evidence at the inquest confirmed Dr O'Dea's assessment. As she described it, psychiatrists were restricted to '*putting out fires'*.

89. Dr O'Dea understood that these restrictions severely compromised his ability to care for patients like F. In his supplementary statement he said:

'Ideally if I was treating [F] in the community, I would see a patient in his condition on at least a one to three monthly basis. As a result of the demand on psychiatric services at Goulburn Correctional Centre, however, the frequency of reviews would be dependent on the competing needs of other inmates and it may be 6 to 12 or even more months, between each of my reviews.'

90. These frustrations were echoed by RN Harris in his evidence at the inquest, which described a similar scarcity of resources for mental health nurses.

91. Dr O'Dea's comments are borne out by the evidence. As we have seen, in the two year period before his death F received a psychiatric review on only three occasions. Furthermore, it appears that after his psychiatric review on 9 December 2015 no time frame was set for his next appointment. At the inquest Dr O'Dea said that he now tried to document a clinically appropriate timeframe

for next review. However he cautioned that given the limited resources available, there was little prospect of being able to meet such a timeframe.

Question of adequacy of resources

92. At the heart of this difficulty is the question whether the level of resources for mental health care in NSW is sufficient to provide an appropriate level of care for inmates such as F. The evidence given by Dr O'Dea, Dr Spencer and Dr Sullivan regarding custodial environments within which they have worked, strongly indicates that it is not.

93. Dr Eagle and Dr Sullivan attested to the high prevalence of mental illness in the inmate population, relative to the general population. Both noted that the incidence of chronic and severe illness in prisons is higher than in the community, in particular schizoaffective and psychotic disorders.

94. These witnesses attested that in their experience, the prevalence of severe mental illness within prisons had not been accompanied by an equivalence of mental health services. Dr Spencer and Dr O'Dea testified to a high degree of competition within NSW for the services of CMH's '*hub'* facilities, forcing JH Network staff to triage their services based on severity and urgency of condition. In their oral evidence Dr Eagle and Dr Sullivan agreed that given the level of psychiatric services available at GCC, it was unlikely that the needs of a patient such as F could be met.

95. Further evidence was available at the inquest regarding the adequacy of resourcing for custodial mental health services. Tendered at the inquest was the document [redacted], about which more will be said later in these findings. This document cited figures from the Bureau of Crime Statistics and Research NSW, showing a steady increase in prison population numbers in recent years.

96. At the inquest Dr Spencer said that there had not been a commensurate increase in workforce levels to cope with the increased workload. She confirmed [redacted]:

[redacted]

97. [redacted]

98. [redacted]

[redacted]

99. I accept the evidence of the four psychiatrist witnesses regarding the challenges of providing mental health services with an insufficiency of resources. All impressed as caring and dedicated practitioners. Just as importantly, I assess them to be credible witnesses who have extensive relevant qualifications and working experience within prisons.

100. The conclusion one reaches on the basis of the evidence is that the nature and level of mental health services available at GCC did not and could not provide an adequate standard of care for F. Furthermore, based on the experiences described by the psychiatrist witnesses, there is a strong likelihood that funding for custodial mental health resources has not kept pace with need.

An alternative psychiatric care model

101. I have noted above the absence in NSW of a long stay psychiatric facility for the care of inmates like F.

102. At the inquest the court heard from Dr Spencer about a proposal for an alternative model of mental health care, for patients with what she described as '*serious and enduring mental illness'.* In Dr Spencer's opinion, F's clinical need for intensive mental health support would have placed him within this category. [redacted].

103. The proposal has been provided to the NSW Ministry of Health and is still under consideration. If implemented the project will also require coordination with CSNSW. I accept that it would not be appropriate to disseminate evidence heard at the inquest about the proposal, before stakeholders including the Ministry of Health have been able to properly consider it. For this reason I have made interim orders for non publication in relation to it. In my published findings I refer to the proposal only as '*the renewed model of care'*, and I have redacted my discussion of the evidence in relation to it.

104. Details of the proposal were provided to the inquest in the form of a document [redacted]

105. [redacted]

[redacted]

106. [redacted].

107. [redacted]

108. [redacted].

109. The evidence heard at inquest about the circumstances of F's sad death exposed a gap in mental health services for long term inmates like F. There is no reason to suppose that this shortfall is confined to the GCC. The renewed model of care, in addition to providing a more contemporary approach to mental health care, would help to fill this gap. It represents a significant and practical step in improving the care of seriously ill inmates like F. Its implementation is worthy of support.

110. I accept the submission advanced on behalf of the JH Network, that potential funding of the renewed model of care will be a matter for the Ministry of Health, who is not a party of sufficient interest in this inquest. I will make the renewed model of care the subject of a recommendation drafted in terms which is intended to meet these concerns.

Changes within the JH Network since F's death

111. Since F died the JH Network has sought to address some of the systemic issues that his death exposed, within the limitations of its resources and funding. These include the following steps:

- development of a new business rule designed to provide better assurance that metabolic monitoring will take place where needed
- introduction of software (Qlikview) to better monitor patient waitlists
- increased psychiatric and nursing coverage, through use of telehealth services throughout the JH Network
- introduction of electronic medical records to improve information flow

- a new method of dispensing daily medication via sachets, reducing time pressures on nurses.

112. In addition, the JH Network has received funding as part of the NSW Government's *Towards Zero Suicides* initiative. This has been applied to create a unit within the Metropolitan Remand and Reception Centre, to house 55 inmates who have a heightened risk of suicide. The new unit, named 'O Block', is to open in the next few months. It is intended that the unit will be less punitive and more therapeutic in its approach, by comparison with the safe cells currently used in NSW's correctional centres.

The question of recommendations

113. Counsel Assisting the inquest provided closing submissions in which she proposed three recommendations arising out of the evidence.

Proposed recommendation 1

114. The first recommendation urged the implementation of the renewed model of care, and that it be separately funded and resourced '*independent of the need to reallocate resources from the existing model of care'*.

115. This recommendation was not supported in submissions advanced on behalf of the JH Network. This was on the basis that:

- the JH Network does not determine its own funding. It operates pursuant to a service agreement with the NSW Ministry of Health, which was not a party of sufficient interest in the inquest

- the JH Network's present funding does not extend to providing care pursuant to the renewed model of care.

116. I accept that these features preclude me making a recommendation in the existing terms. The JH Network is unable to implement the renewed model of care without the agreement of the Ministry of Health. Nor is the JH Network able to make decisions about the level of its own funding and resourcing.

117. Nevertheless I wish to provide as much support to the renewed model of care as is available within my role. It cannot be known if F's death would have been averted had he been able to be accommodated in a secure psychiatric environment. However the evidence was overwhelming that the custodial setting was incapable of providing him with the care that he required. The renewed model of care offers an alternative, with the hope of better meeting the needs of inmates such as himself.

118. I therefore make the following recommendation:

To the CEO of the Justice Health and Forensic Mental Health Network:

That the JH Network use these findings to advance the position before the Ministry of Health that the renewed model of care [redacted] be implemented in consultation with CS(NSW)

119. I have not recommended that the renewed model of care be separately funded and resourced. This is not in any way because the evidence suggested that additional funding for this project and for custodial mental health services generally was not greatly needed. On the contrary, the evidence was compelling that CMH services are overstretched, and that the care that can be provided to severely ill inmates suffers as a result.

120. I have avoided any recommendation regarding how the renewed model of care is to be funded, because I recognise that the manner in which public funds are to be allocated is appropriately left to the members of the executive government.

121. I will however provide a copy of these findings to the Ministry of Health for consideration of its contents.

Proposed recommendation 2

122. The second proposed recommendation was that the JH Network develop a guideline in relation to decisions about unsupervised medication.

123. The expert evidence regarding F's medication care supports the conclusion that there were gaps in its implementation which may have contributed to his death. I refer here to the decision that he be allowed to take his medication on an unsupervised basis, in circumstances where monitoring of his compliance did not take place. I refer also to the decision that he be permitted to receive his medication in monthly batches without consultation with his treating psychiatrist.

124. According to submissions advanced on behalf of the JH Network, new guidelines [referred to as *Medication Guidelines published in January 2021*] now mandate that a decision for self medication be made only by the inmate's prescribing medical officer. But my reading of the extract which was provided within those submissions does not support this interpretation. Clause 6.6.1 of the new Guideline states that the decision is to be made '*by the prescribing medical officer or nurse practitioner, the NUM or delegate and Pharmacy Department staff*'.

125. Neither this provision, nor the proposal that *changes* to a self medication program should be made by this group of people, is in my view sufficient to meet the concerns identified in the inquest.

126. I make the following recommendation:

To the CEO of the Justice Health and Forensic Mental Health Network:

That in relation to patients approved for unsupervised medication, consideration be given to developing a guideline outlining that any alteration to the patient's medication regime in relation to antipsychotic and antidepressant medication be approved by the patient's treating psychiatrist. An alteration includes any modification to the type, dosage or frequency of medication, including any shift from daily to monthly dispensing. Such guideline should be disseminated to JH Network staff and Visiting Medical Officers and incorporated in relevant induction and annual training.

Proposed recommendation 3

127. The third proposal was that the JH Network consider developing health care plans for patients at GCC who suffer chronic and major mental health illness.

128. This recommendation arose from Dr Eagle's advocacy, in her report and oral evidence, for a case management plan for patients like F who require regular monitoring of their mental state and compliance, in addition to a plan for relapse prevention and recovery.

129. Dr Sullivan in his report supported the requirement that there be a chronic health care plan for inmates such as F, to '*reduce the likelihood of further episodes of mental illness.'* In his oral evidence he added that such a health care plan needed elements not only as to medication but also preventive measures.

130. However Dr Sullivan and Dr Spencer cautioned that the kind of model contemplated by Dr Eagle was not realistic in a correctional setting without appropriate resourcing and funding. The proposed recommendation was not supported by the JH Network for those reasons.

131. Although it appears likely that the proposal for chronic mental health care plans would benefit patients, I recognise that current levels of funding and resourcing make this recommendation unfeasible.

Conclusion

132. In closing, and on behalf of the coronial team, I offer my sincere and respectful sympathy to F's family.

133. I acknowledge the excellent assistance I have received from those who assisted me, Ms Christine Melis of Counsel and Ms Amber Doyle of NSW Crown Solicitor. I also acknowledge the assistance of the other legal representatives appearing in the inquest. My thanks also to Detective Sergeant Andrew Tesoriero for his investigation and preparation of the matter for inquest.

Findings required by s81(1)

134. 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.

Findings:	**Identity** The person who died is [redacted]. **Date of death**: [redacted] died between 24 and 25 May 2017 . **Place of death**: [redacted] died at Goulburn Correctional Centre, Goulburn NSW. **Cause of death:** [redacted] died as a result of hanging. **Manner of death:** [redacted] death was an intentional self inflicted death, at a time when he was a sentenced prisoner at Goulburn Correctional Centre.

135. I close this inquest.

E Ryan
Deputy State Coroner
Lidcombe

Date 11 June 2021