CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Dimitrios Mavris
Hearing dates:	2 to 6 November 2020; 21 December 2020
Date of findings:	19 February 2021
Place of findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, Surry Hills Cells Complex, role of Corrective Services New South Wales Monitor officer, permissibility of Corrective Services New South Wales officers watching television whilst on duty, risk of self-harm, appropriate monitoring of inmates, nature and quality of CCTV footage, use of the Morseman Tour Guard Wand
File number:	2018/166031
Representation:	Ms S Callan SC & Ms J Curtin, Counsel Assisting, instructed by Mr P Armstrong (Crown Solicitor's Office) Mr G Gemmell for the Commissioner of Corrective Services New South Wales, instructed by Department of Communities and Justice, Legal Ms D New for the New South Wales Commissioner of Police, instructed by New South Wales Police Force Office of General Counsel Mr C O'Neill for the Mavris family, instructed by Fortis Law Group Mr S Russell for Assistant Superintendent D Yarnton, Assistant Superintendent W Searle, Senior Corrections Officer J Sawhney, and First Class Correctional Officers D Walker, N Bissett, M Sellman & B Denyer, instructed by McNally Jones Staff Lawyers

Findings:	I find that Dimitrios Mavris died on 25 May 2018 at the Surry Hills Cells Complex, Sydney Police Centre, Surry Hills NSW 2010. The cause of Mr Mavris' death was hanging. Mr Mavris died whilst in lawful custody, after having been refused bail, as a result of actions taken by him with the intention of ending his life.
Recommendations:	See Appendix A
Non-publication orders:	See Appendix B

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1. Introduction

1.1 On 23 May 2018 Mr Dimitrios Mavris was arrested by Australian Federal Police agents at Sydney International airport. He was subsequently charged with a drug importation offence and transferred to the Sydney Police Centre at Surry Hills. After being denied bail Mr Mavris was then transferred into the custody of Corrective Services New South Wales, and held in a cell within the Surry Hills Cells Complex from the early hours of the morning on 24 May 2018. Mr Mavris remained in his cell for the remainder of 24 May 2018.

1.2 At around midday on 25 May 2018 Mr Mavris engaged in behaviour within his cell that was directed towards intentionally causing his own death. This behaviour involved fashioning a ligature from his clothing and a blanket, and attempting to affix the ligature to potential anchor points within his cell.

1.3 At around 6:30pm on 25 May 2018 Mr Mavris placed the ligature around his neck and affixed it to the door frame of his cell. He became unresponsive several minutes later. At 6:37pm an alarm was raised with Corrective Services New South Wales officers. An emergency medical response was initiated but despite resuscitation attempts Mr Mavris could not be revived and was later pronounced life extinct. At the time of his death Mr Mavris had been in lawful custody for approximately 40 hours.

2. Why was an inquest held?

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

2.2 When a person is charged with an alleged criminal offence, or is sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be investigated in an objective manner. This is because a coronial investigation and an inquest seek to examine the circumstances surrounding that person's death in order to ensure, through an independent and transparent inquiry, that the State appropriately and adequately discharges its responsibility.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels

a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum.

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

3. Recognition of Mr Mavris' life

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

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

3.3 Mr Mavris[1] was born in Cyprus on 27 December 1969. He was married to his wife, DM, and together they had three children: AM, NM and CM.

3.4 Mr Mavris previously worked as a mechanic for many years. However he later operated a scaffolding business, and became involved in property development and other entrepreneurial activities.

3.5 Mr Mavris was known for his selfless qualities, always choosing to see the good in people, being extraordinarily generous with his time, and making himself available to anyone in need regardless of whether he knew them or not. DM describes her husband as being the type of man who would give the shirt off his back to anyone that needed it.

3.6 Mr Mavris had a remarkable and caring attitude towards children. DM fondly recalls that children were drawn to Mr Mavris because of his down-to-earth nature and the wonderment they found in the magic tricks that he would perform for them. However, it is abundantly clear that, apart from his wife, the most loving and special relationships that Mr Mavris enjoyed was with his own children.

3.7 At the conclusion of the evidence in the inquest Mr Mavris' children honoured those present in court by sharing some private and treasured memories of their father. Their words were truly heartbreaking to hear. Each of Mr Mavris' children spoke of their adoration for their father, his

[1] Although Mr Mavris was known to his family and friends as Jim, in accordance with the wishes of his family he was referred to as Mr Mavris during the inquest, and will again respectfully be referred to in the same terms in these findings.

kindness, his generosity, his gentle and non-judgemental nature and his inherent ability to make others laugh and feel at ease. Each of Mr Mavris' children also spoke of the milestones in life that they will now forever be denied from sharing with their father: learning how to drive, graduating from university, getting married, buying their first home and introducing their children to their grandfather.

3.8 Whilst it is not possible to quantify how much Mr Mavris is missed by his family, the many people that attended his funeral to mourn his passing is indicative of the high regard in which he was held by those closest to him.

3.9 There can be no doubt that Mr Mavris' passing has been devastating for his wife, children and loved ones. It is equally distressing to know that Mr Mavris' family have been made to endure enormous grief and trauma amidst the media scrutiny associated with his passing.

4. Background to the events of May 2018[2]

4.1 On 23 March 2018 two shipping containers of frozen fish were imported from Peru, via Columbia, to Australia. The containers were consigned to Mazzo Investments Pty Ltd, a company which did not exist. However a company by the name of Mazzco Investments Pty Ltd was, at the time, registered with the Australian Securities Investment Commission, with Mr Mavris listed as the sole director, secretary and shareholder of the company.

4.2 Upon arrival in Australia, the shipping containers were inspected by the Australian Border Force. When the shipping containers were subjected to x-ray examination a number of anomalies were identified. The containers were subsequently searched and found to contain 30 blocks of cocaine in one container, and 29 blocks of cocaine in the other. Each block of cocaine weighed approximately one kilogram, meaning that a total of approximately 59 kilograms of cocaine was located in the two shipping containers.

4.3 The cocaine was subsequently removed from the shipping containers and the Australian Federal Police (**AFP**) arranged for a controlled delivery of the containers, under both physical and electronic surveillance. This surveillance indicated that Mr Mavris inspected the containers several times, observing that the cocaine had not been secreted in the containers as anticipated.

4.4 On 13 May 2018 Mr Mavris travelled to Bogota, Colombia. The AFP considered this trip to be for the purpose of Mr Mavris meeting with unidentified members of a drug syndicate in order to discuss the importation of the cocaine.

5. What happened on 23 May 2018?

5.1 At 5:50pm on 23 May 2018 Mr Mavris returned to Australia, arriving at Sydney International Airport on an overseas flight from Columbia. At around 7:00pm Mr Mavris was arrested by Federal Agents Dunbar and Blunden for an offence of importing a commercial quantity of cocaine. He was searched and then taken to the Sydney office of the AFP.

[2] This factual background has been drawn from the helpful opening address of Counsel Assisting.

5.2 At 8:20pm Federal Agents commenced an electronically recorded interview with Mr Mavris, during which he denied having any knowledge of the cocaine that had earlier been found in, and removed from, the two shipping containers. Instead, Mr Mavris maintained that he had arranged for the importation of two containers of frozen fish to sell for bait as part of a profitable venture. However, Mr Mavris acknowledged that he was in financial difficulties. Further, when asked about the purpose of his trip to Columbia, Mr Mavris indicated that he had been experiencing a significant amount of stress and needed to "*get away*".[3] The interview concluded at 11:56pm. Following this, Mr Mavris agreed to take part in a forensic procedure which involved the taking of a buccal swab.

5.3 Mr Mavris was subsequently charged with importing a commercial quantity of a border controlled drug, namely cocaine, contrary to section 307.1 of the *Criminal Code* (Cth). Federal Agent Nathan Robertson had a conversation with Mr Mavris regarding the charging process and the seriousness of the offence, explaining that the maximum penalty is life imprisonment. Federal Agent Robertson observed that Mr Mavris appeared weary, which he attributed to the effects of a long haul flight from Chile.

6. What happened on 24 May 2018?

6.1 At about 1:15am on 24 May 2018 Mr Mavris was taken from the Sydney office of the AFP to the NSW Police Force (**NSWPF**) Sydney Police Centre (**SPC**) at Surry Hills. Located within the SPC is the Surry Hills Cells Complex (**Surry Hills Cells**) which is frequently used to house inmates on remand prior to their transfer to a correctional centre.

6.2 Upon admission, Mr Mavris was refused bail by Leading Senior Constable Charles Cook on the basis that he had been charged with a Show Cause offence. Mr Mavris was subsequently remanded to appear at Central Local Court.

6.3 At about 2:20am Leading Senior Constable Cook completed a NSWPF Custody Management Record which relevantly recorded that Mr Mavris showed no signs of mental illness or self-harm, no agitation or aggressiveness, no scars or injuries that would suggest any previous attempt at self-harm, and that no threat of self-injury in custody had been made by Mr Mavris. The Custody Management Record also noted that Mr Mavris denied ever trying to kill himself, and that Mr Mavris indicated that this was not the first time he had been arrested and placed in police custody.

6.4 Mr Mavris was subsequently taken into custody by Corrective Services New South Wales (**CSNSW**) officers. At about 2:35am Correctional Officer Adrian Dowell completed a *New Inmate Lodgement & Special Instruction Sheet* which recorded that Mr Mavris indicated that he had no immediate medical issues, no mental issues for which he had been receiving treatment, that he had never tried to hurt himself, never tried to end his life, and that he was "*feeling fine*".[4] Officer Dowell formed the impression that Mr Mavris showed no signs of suicide, self-harm, agitation, aggression, depression or withdrawal.

[3] Exhibit 1, Tab 33, page 78.
[4] Exhibit 1, Tab 45, page 5.

6.5 At 2:43am Mr Mavris entered Cell 1 of the Surry Hills Cells. He was wearing his own clothes, namely a blue button up collared shirt over a black T-shirt, trousers, and boxer shorts. Mr Mavris remained in these clothes throughout his time in custody.

6.6 At 9:30am Mr Mavris' matter was listed at Central Local Court in relation to the question of bail. A solicitor appeared for Mr Mavris and it appears that bail was not applied for. Accordingly, Mr Mavris' matter was adjourned to 30 May 2018 for a bail application, and Mr Mavris was remanded into custody, bail refused.

6.7 At 3:44pm Mr Mavris was transferred from Cell 1 to Cell 20. At the time, this latter cell housed two other inmates, Mr NR and Mr ND.

7. What happened on 25 May 2018?

7.1 At 6:37am on 25 May 2018 Mr Mavris was provided with breakfast, with his meal including a plastic knife. Later that morning at 9:38am Mr Mavris was escorted from his cell in order to meet with his solicitor. He later returned to his cell at 11:15am and appeared to take a nap. At 11:26am one of Mr Mavris' cellmates, Mr NR, was transferred out of Cell 20 and did not return. Mr Mavris remained in Cell 20, together with Mr ND.

7.2 In the period between 11:50am and 1:40pm on 25 May 2018 Mr Mavris was captured on CCTV engaging in behaviour consistent with attempted self-harm. During this period Mr Mavris created a ligature using his shirt and a blanket. He appeared to affix this ligature to several potential anchor points within his cell and then test their efficacy. Mr Mavris also used the plastic knife obtained from his breakfast meal to alter the ligature in order to make it easier to attach to an anchor point. Mr Mavris then appeared to make several self-harm attempts, including the following:

(a) At 12:10pm Mr Mavris attempted to tie the sleeve of his shirt around his neck;

(b) At 12:45pm Mr Mavris placed the shirt around his neck whilst lying on his mattress, and pulling at the shirt;

(c) At 1:40pm Mr Mavris stood next to his mattress with his shirt around his neck, and pulled on the shirt.

7.3 At 2:00pm there was a change in shift between the CSNSW officers who were rostered to work at the Surry Hills Cells on that day. The officers in the A Watch ended their shift and were replaced by officers in the C Watch. There is no evidence that any of the A Watch officers had observed Mr Mavris' self-harm attempts between 11:50am and 1:40pm earlier that day. Equally, there is no evidence that during any handover between each Watch any aspect of Mr Mavris' behaviour earlier that day was discussed.

7.4 Between 1:41pm and 5:21pm Mr Mavris remained in his cell, spending much of his time resting and showing no behaviour out of the ordinary.

7.5 At 5:21pm Mr Mavris and Mr ND were both provided with dinner in their cell by Officer Neil Bissett. Following this, Officer Bissett returned to Cell 20 at 5:39pm in the company of Registered Nurse (**RN**) Miriam Doggett, the Justice Health & Forensic Mental Health (**Justice Health**) nurse on duty, in order to perform a head check, and check on the inmates' medical welfare. Mr Mavris approached the cell door and said that he did not need anything.

7.6 At 6:00pm the lights in the individual cells were turned off after the inmates had been provided with their evening meal, in accordance with usual practice at the time. CCTV footage of Cell 20 shows that at 6:10pm Mr Mavris tied his shirt around his neck and spoke to Mr ND. Mr Mavris reportedly told Mr ND, "*I want to kill myself, come help me kill myself*". In response, Mr ND told Mr Mavris, "*I'm not dumb, I'm not gonna do it. I'm not going to do life for you*". Notwithstanding, Mr Mavris lay down on the mattress with his shirt wrapped around his neck and asked Mr ND to pull the shirt. Mr ND complied and began pulling on the shirt for less than one or two minutes before suddenly letting go, telling Mr Mavris, "*No I can't do it*", and "*I don't want to do it, there is a camera here*". Mr Mavris pleaded with Mr ND to continue, but Mr ND responded, "*I can't help you*".

7.7 At 6:13pm Mr ND returned to his own bed, lay down and faced the wall. He reportedly then went to sleep for a short time.

7.8 At 6:14pm, CSNSW Officer David Walker was in the reception area of the Surry Hills Cells. This area contains four screens which show CCTV footage from individual cells. Officer Walker used a remote control to change one of the four screens displaying CCTV footage of individual cells to, instead, free to air television. The CCTV screen that was changed by Officer Walker did not show CCTV footage from Cell 20. That footage remained visible on one of the three other CCTV screens.

7.9 At 6:15pm, Mr Mavris continued to pull on the shirt by himself, attempting to tighten the ligature around his neck.

7.10 Approximately two minutes later Mr Mavris affixed the ligature he had created using a blanket and his shirt between the cell door frame and a wall. At 6:28pm Mr Mavris placed his shirt back around his neck. Approximately two minutes later at 6:30pm Mr Mavris sat down, with the ligature positioned around his neck. At 6:33pm Mr Mavris can be seen on the CCTV footage to no longer be moving.

7.11 At 6:37pm Mr ND got out of his bed, walked over to where Mr Mavris was located and touched Mr Mavris' head. Mr ND subsequently used the cell intercom to call CSNSW officers located at the reception area telling them that Mr Mavris had "*hanged himself*" and that "*someone hanged themselves*". At the time of Mr ND's cell call alarm (known colloquially within the corrections environment as a "knock up") Officer Neil Bissett and Officer Walker were facing the screens, apparently watching television, whilst Officer Sawhney was seated at the workstation in the reception area eating his evening meal.

7.12 At 6:38pm CSNSW officers left the reception area, arriving at Cell 20 a minute later. Officer Bissett found Mr Mavris sitting with his back to the cell wall, with the ligature tied around his neck and with no signs of life. Officer Bissett instructed Officer Searle to retrieve what is commonly known as the 911, a tool used to cut a ligature in the event that an inmate is involved in a self-harm hanging

incident. Meanwhile Officers Bissett and Walker attempted to lift Mr Mavris in order to remove the strain from his neck, but they were unsuccessful. Officer Walker then attempted to loosen the ligature by inserting his hand between the ligature and Mr Mavris' neck.

7.13 Officer Searle returned to the reception area at 6:39pm and retrieved the 911 tool, whilst also instructing Officer Sawhney to call for a Justice Health nurse. After returning to Cell 20, Officer Searle unsuccessfully attempted to cut the ligature free using the 911 tool, before Officer Bissett took over and was able to cut the ligature.

7.14 Mr Mavris was placed on his side on the ground. He was noted to be unresponsive and not breathing, with his eyes open. RN Doggett arrived at Cell 20 at 6:40pm. She checked for a pulse, also observed that Mr Mavris was not breathing, and then commenced cardiopulmonary resuscitation (**CPR**) using a bag valve mask. Later RN Doggett switched to a laerdal mask as she was unsatisfied with the seal of the bag valve mask. RN Doggett also applied a defibrillator to Mr Mavris at 6:44pm which detected no shockable rhythm. CPR continued.

7.15 After moving Mr ND to a different cell, Officer Walker returned to the reception area at 6:41pm and switched the monitor displaying television to its usual display of CCTV footage from individual cells.

7.16 NSW Ambulance paramedics were despatched at 6:42pm and arrived at Cell 20 at 6:50pm. They took over CPR from RN Doggett and continued until further paramedics arrived at 6:53pm. By this stage Mr Mavris was noted to be in asystole, pulseless and peripherally cyanosed but still warm to the touch. Cycles of CPR continued and Mr Mavris was cannulated and intubated. His heart rate subsequently changed from asystole to pulseless electrical activity.

7.17 At 7:11pm Mr Mavris was removed from Cell 20 by attending paramedics and loaded into an ambulance at 7:22pm. He was transferred to St Vincent's Hospital, arriving at 7:28pm and then triaged a short time later. Despite continued resuscitation efforts Mr Mavris could not be revived and was pronounced life extinct at 8:00pm.

8. What was the cause and manner of Mr Mavris' death?

8.1 Mr Mavris was subsequently taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Istvan Szentmariay, forensic pathologist, on 29 May 2018. Dr Szentmariay noted that there was a broad-based pale ligature mark over the anterior aspect of the neck, but that the cervical spine and laryngeal hyoid bone were intact. In the autopsy report dated 31 May 2019 Dr Szentmariay opined that the cause of Mr Mavris' death was hanging.

8.2 In a supplementary report dated 3 November 2020, Dr Szentmariay noted that every minute after hanging can decrease the chance of successful resuscitation. Further, whilst resuscitation may result in the return of spontaneous circulation after an extended period of time (20 to 40 minutes), irreversible brain damage is typically caused after a relatively short period of time (5 to 10 minutes).

8.3 Given the gravity of a finding that a person has intentionally inflicted their own death it is well-established that such a finding cannot be assumed, but must be proved on the available evidence. Mr Mavris' actions during the period between 11:50am and 1:40pm on 25 May 2018, his interactions and conversation with Mr ND in the brief period after the cell lights were turned off at 6:00pm, and Mr Mavris' own actions at 6:30pm in placing the ligature around his neck and affixing it to the cell door frame all demonstrate an intention by Mr Mavris to inflict his own death.

8.4 **Conclusions:** Having regard to the above, there is sufficiently clear and cogent evidence to establish that Mr Mavris died as a result of actions taken by him on the evening of 25 May 2018 with the intention of ending his life. The cause of Mr Mavris' death was hanging.

9. What issues did the inquest examine?

9.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the matters to be considered. That list identified the following issues:

(a) Whether CSNSW adequately managed Mr Mavris' risk of suicide while he was in custody at the Surry Hills Cells in the SPC, including:

(i) the adequacy of the information provided by the AFP to CSNSW as to Mr Mavris' mental health upon his transfer to the Surry Hills Cells;

(ii) the adequacy of the assessment conducted by CSNSW of Mr Mavris' mental health upon his admission to custody;

(iii) the adequacy of monitoring of Mr Mavris by CSNSW whilst in custody;

(iv) whether CSNSW has mechanisms in place to adequately monitor inmates;

(v) the appropriateness or otherwise of cell architecture, in relation to hanging points;

(vi) consideration of any materials available to inmates to create ligatures (including the practice of permitting inmates to remain in their own clothes); and

(vii) the practice of keeping inmates at the Surry Hills Cells for up to 72 hours before transfer to a correctional centre;

(b) Whether the matter ought be referred to CSNSW for review in relation to possible disciplinary action against involved officers.

10. Operational features of the Surry Hills Cells Complex as at May 2018

10.1 Before going on to consider a number of specific issues that the inquest was concerned with, it is convenient to describe some operational features of the Surry Hills Cells relevant to these issues.

Physical layout

10.2 In order to enter the actual cells within the Surry Hills Cells it is first necessary to pass through an area where inmates are received and processed (**the Reception Area**) by CSNSW officers. Located within the Reception Area is a workstation, where CSNSW officers perform certain duties including answering knock ups made by inmates from their cells, and communicating with vehicle entry points at the SPC that were used for the transfer of inmates. A small office used by the CSNSW Officer-in-Charge (**OIC**) for each Watch and an office used by the Justice Health nurse on duty are also located with the Reception Area.

CCTV footage

10.3 As at May 2018 each individual cell within the Surry Hills Cells contained a CCTV camera which streamed real-time footage to a bank of four display screens (**the CCTV screens**) in the Reception Area. The CCTV screens are located on a wall perpendicular to the workstation, and are able to be viewed from most points within the Reception Area, except from within the offices referred to above. Relevantly, it is possible for a CSNSW officer to be performing duties at or near the workstation and be able to see the CCTV screens.

10.4 Each CCTV screen is divided into nine images, in a three by three grid, with each image showing CCTV footage from the cells and exit/egress points in the complex. As at May 2018 it was possible for the CCTV screens to be manually switched from displaying CCTV footage from individual cells to displaying free-to-air television.

10.5 There is also a CCTV camera in the Reception Area itself which records activity within it, and captures both the workstation and CCTV screens.

Division of CSNSW officer duties into Watches

10.6 CSNSW officers on duty at the Surry Hills Cells were rostered on to shifts, described as Watches, during the day and night. CSNSW officers were rostered on the A Watch, B Watch or C Watch. Relevantly for 25 May 2018 the C Watch was between 2:00pm and 10:00pm.

10.7 On 25 May 2018 the following CSNSW officers were rostered on the C Watch:

(a) Assistant Superintendent (**AS**) Warren Searle who was the OIC;

(b) Senior Corrections Officer Jasdeep Sawhney who was the Second in Charge (**2IC**);

(c) First Class Correctional Officer David Walker, who was initially rostered on the Control role;

(d) First Class Correctional Officer Neil Bissett, who was initially rostered on the Cells role;

(e) First Class Correctional Officer Bryan Denyer, who was initially rostered on the Monitor role.

10.8 The officers rostered on the Control, Cells and Monitor roles would rotate through each role at regular intervals during the course of a Watch. For example, an officer on the C Watch who commenced duties at 2:00pm in the Control role would rotate to the Cells role at 4:30pm, and then rotate again to the Monitor role at 7:00pm, before ceasing duty at 10:00pm.

Roles and duties of the CSNSW officers

10.9 As noted above CSNSW officers who performed duties at the Surry Hills Cells rotated between the Monitor, Cells and Control roles each shift. These roles were common across all three Watches. Each role had a specific set of duties and responsibilities. However it was the role of the Monitor that was closely examined at the inquest.

10.10 The Monitor role was created in January 2018 (and later filled by February/March 2018) to meet obligations arising under the CSNSW Custodial Operations Policies and Procedures (**COPP**). Section 3.7 of the COPP provides for the management of inmates at risk of self-harm or suicide. It specifically requires that "*immediate action must be taken following identification of risk of suicide or self-harm*", and that "*[o]ne of these actions is to make a mandatory notification about an inmate at risk of suicide or self-harm*".[5]

10.11 Section 3.7 also provides that "*[t]he primary purpose of mandatory notification is to ensure that all relevant staff are aware of inmates who require additional management strategies to prevent suicide or self-harm, and to ensure that appropriate care is provided for the inmate's health and safety*".[6] all inmates who are the subject of a mandatory notification must have an Immediate Support Plan (**ISP**) developed. An ISP is "*a plan to manage an inmate immediately after they have been identified as being at risk of suicide or self-harm*".[7]

10.12 Section 3.7 of the COPP also provides that following a management identification and development of an ISP a Risk Intervention Team (**RIT**) must convene. The RIT is then responsible for a number of matters, including ongoing assessments of an inmate's risk of suicide of self-harm, and developing and reviewing a RIT Management Plan to manage an inmate's risk.

10.13 At the time that the Monitor role was introduced a set of post duties was created which described the duties and responsibilities of the officer performing the role. Similar post duties were also created for both the Cells and Control roles. According to the post duties the role of the Monitor on the C Watch was to: "*Take up monitor room duties… (1.2) Perform duty as per Departmental regulations, rules and procedures… (1.5) Maintain a vigilant watch on all ISP inmates and record all alarms on inmate monitoring system*".

10.14 The Post Duties for the C Watch (when there were less than 41 inmates in the Surry Hills Complex) in 2018 provided the following duties for the officer performing the Monitor role between 2:00pm and 7:00pm: "*Monitor Room, Answer Knock Up's [sic], (Answer Phone When Truck's [sic] in*". Additionally, from 7:00pm to 10:00pm the Monitor is to perform the following duty: "*Morseman & Head Check at 9:30pm*".

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[5] Exhibit 1, Tab 66, page 8.
[6] Exhibit 1, Tab 66, page 8.
[7] Exhibit 1, Tab 66, page 32.

Morseman Tour Guard Wand

10.15 The Morseman Tour Guard Wand (**Morseman Wand**) is a device which is pressed to a docking ring outside individual cells which records the time and date that a cell inspection is performed. The CSNSW *Standard Operating Procedures – SWTC, Section 30: Moseman [sic] Wand* (drafted on 9 February 2009) (**Morseman SOP**) provides at clause 4.3.2 that the Morseman Wand is to be used generally every hour by a first class correctional officer during each Watch and that all docking ports will be activated at least once. Further, clause 4.3.3 provides that when a mandatory notification is put in place the Morseman Wand will be used as per the management plan, generally being every 10 to 30 minutes.

10.16 In addition, a document authored by AS Yarnton and titled "*Head Check and Morseman Check*" (**the Head Check document**) was displayed on a board in the Reception Area. The Head Check document was on display on 25 May 2018, and provided that a head check was to be performed three times each day using the Morseman Wand: at 6:00am during the A Watch, at 9:30pm during the C Watch, and at 5:30am during the B Watch.

11. Was adequate information provided by the Australian Federal Police to Corrective Services New South Wales?

11.1 Following Mr Mavris' interview at the Sydney office of the AFP, Federal Agent Nathan Robertson engaged in a brief conversation with Mr Mavris during which he explained a number of matters related to the charging process. Federal Agent Robertson explained the charge to Mr Mavris, the applicable maximum penalty and matters relevant to the question of bail.

11.2 Federal Agent Robertson gave evidence that during this interaction Mr Mavris displayed little emotion, and only asked questions in relation to the likelihood of bail. In response, Federal Agent Robertson explained that whilst the AFP would request that bail be refused that issue was initially not a matter for the AFP to determine. Federal Agent Robertson indicated that whilst Mr Mavris appeared weary, he did not ask Mr Mavris about his apparent weariness or any mental health issues. Federal Agent Robertson explained that if Mr Mavris had said or done anything which indicated the possibility of suicidal ideation that he would have sought advice from the AFP and that this information would have been conveyed to the custody manager at the SPC.

11.3 Federal Agent John Turner assisted in escorting Mr Mavris from the Sydney office of the AFP to the Surry Hills Cells. During this process Mr Mavris indicated that he was tired and asked about an opportunity to sleep. Federal Agent Turner gave evidence confirming that Mr Mavris appeared tired, but that he was otherwise polite and quiet, and compliant in relation to all of his interactions with AFP Agents. Federal Agent Turner also gave evidence that if he had observed from Mr Mavris' state any matter which suggested a mental health issue he would have communicated this to the charging officer or custody manager at the SPC.

11.4 **Conclusions:** There is no evidence to suggest that, during his interactions with AFP Agents prior to his transfer to the SPC, Mr Mavris displayed any signs of suicidal ideation or any indication that he planned to self-harm. It is clear from the evidence of Federal Agents Robertson and Turner that if any such signs had been identified, appropriate steps would have been taken to convey this information to NSWPF officers upon Mr Mavris' admission to the SPC and, eventually, the Surry Hills Cells. Therefore, the AFP provided adequate information to the NSWPF upon the transfer of custody of Mr Mavris.

12. Was an adequate assessment conducted by Corrective Services NSW of Mr Mavris' mental health upon his admission to custody?

12.1 The NSWPF Custody Management Record for Mr Mavris disclosed no history of mental illness, self-harm, or any threat of self-injury whilst in custody. Similarly the *CSNSW New Inmate Lodgement & Special Instruction Sheet* (**the Lodgement Sheet**) identified that Mr Mavris had no immediate medical concerns. Further, the Lodgement Sheet specifically identified that Mr Mavris had nil medical issues requiring Justice Health review on reception, and that Mr Mavris had never previously tried to hurt himself or end his life. When asked a specific question as to how he felt at the time that the Lodgement Sheet was completed, Mr Mavris indicated that he was "*feeling fine*".[8]

12.2 Each of the CSNSW officers on duty during the C Watch on 25 May 2018 gave evidence that they had previously attended an ISP workshop as part of their overall training. Each of the officers also gave evidence that, as part of the training, they were aware that for some offenders the front end of the correctional chain is a high-risk time, that the first few hours in police or correctional custody is known to be a very high risk period, and that the risk of suicide is dynamic and can change within seconds and hours. Each of the officers also agreed that, based upon this training, the assessment of risk factors for attempted suicide begins from the moment that an inmate is received into the care of CSNSW staff.

12.3 Section 1.1 of the COPP deals with reception procedures. Clause 6.1 of Section 1.1 deals specifically with the risk of self-harm and provides that an ISP and a mandatory notification form must be completed if an inmate is identified as being at risk of self-harm.

12.4 **Conclusions:** Based upon the available information that could be gleaned from Mr Mavris' interactions with Federal Agents and NSWPF officers up to the point that he was received into custody by CSNSW officers at the Surry Hills Cells, together with the contents of the Custody Management Record, there was nothing to suggest that Mr Mavris warranted being placed on an ISP. As already noted above, there was nothing to suggest that Mr Mavris had expressed suicidal ideation or that he was contemplating self-harm. To this extent, the initial assessment conducted by CSNSW officers at the point of Mr Mavris' admission was adequate.

12.5 However, for reasons which are explored in more detail below the adequacy of the assessment conducted by CSNSW officers ought not to be limited to the initial intake period.

[8] Exhibit 1, Tab 45, page 3.

13. Was Mr Mavris appropriately monitored by Corrective Services NSW whilst in custody, and does CSNSW have appropriate mechanisms in place to adequately monitor inmates?

13.1 It is convenient to consider these two issues together. Examination of the appropriateness of the monitoring of Mr Mavris by CSNSW officers, and the adequacy of mechanisms to monitor inmates in general, requires consideration of a number of discrete issues. These will be dealt with in turn below.

Effectiveness of the Monitor role

13.2 It became clear during the course of the inquest that whilst the duties and responsibilities of the officer performing the Monitor role are explicitly stated and understood when there is an inmate on an ISP, the situation is quite different when there is no such inmate on an ISP.

13.3 Craig Osland, the General Manager of the Court Escort Security Unit (**CESU**), was asked about his expectation of the role and responsibilities of the Monitor in circumstances where there was no inmate on an ISP in the Surry Hills Cells. Mr Osland gave evidence that, "*[s]hould there be nobody in the cell location under mandatory notification either by immediate support plan or any other observation regime, that that [sic] Officer whilst within the proximity of the monitoring room area, answering telephones, accessing or assisting to access control for staff; perhaps assisting in the clinic, which is adjacent to the monitoring room area; make notations on the whiteboard in relation to cell population, the names and details of officers who are arriving or are being discharged. I have those types of duties [sic] could very well be delegated onto that person should there be nobody under observation*".[9] Mr Osland also gave evidence that around the time that the Monitor role was introduced he had a conversation with AS Yarnton in which he communicated his expectation as set out above.

13.4 Mr Osland also gave evidence that he had an expectation, in circumstances where there was no inmate on an ISP at the Surry Hills Cells, that the CCTV screens in the Reception Area would be used by the Monitor to perform "*general observations*".[10] However, whether the responsibility to perform general observations using the CCTV screens was the sole responsibility of the Monitor is unclear from Mr Osland's own evidence.

13.5 Mr Osland was asked in evidence to identify any provision within the post duties for the Monitor that indicates that a Monitor is to maintain general observation of the CCTV screens. In answer, Mr Osland referred to clause 1.4 of the post duties which provides that the Monitor is to "*[e]nsure strict security and control of inmates at all times*". However this clause appears in identical terms in the post duties for officers performing the Cells and Control roles, suggesting that the expectation to perform general observations of the CCTV screens (when there was no inmate on an ISP) was not limited solely to the Monitor.

13.6 The evidence established that AS Yarnton had a very different understanding to that of Mr Osland as to the role of the Monitor when there was no inmate on an ISP. AS Yarnton gave evidence that

[9] 6/11/20, T91.41-49.
[10] 6/11/20, T92.34-42.

shortly after the Monitor role was introduced at Surry Hills, he considered it to be "*pure overkill*", variously describing it as a "*free post*" and an "*extra post*", and that he fought against the position. AS Yarnton explained in evidence: "*I believe we didn't need it because we had a regime that when we had an ISP we got an extra officer…The monitor officer was just pure overkill as far as I was concerned. It was just another post to sit there and, you know, 'cause had the [sic] RIT officers there to monitor RITs*".[11]

13.7 AS Yarnton also gave evidence of a conversation with Mr Osland in which the latter expressed no issue with the Monitor being used for other roles throughout the complex (such as assisting with the unloading of inmates from a truck, feeding inmates, and taking inmates to see a Justice Health nurse) provided that there were no inmates on an ISP. According to AS Yarnton the only limitation that was placed on him so far as the role and responsibilities of the Monitor was that he "*wasn't to strip the [Monitor] post*".[12]

13.8 Notwithstanding the divergent views of AS Yarnton and Mr Osland regarding the role of the Monitor, it is clear that the Monitor role was utilised in the way that AS Yarnton intended, namely to perform duties both in the Reception Area and elsewhere throughout the Surry Hills Cells. Indeed, none of the CSNSW officers on the C Watch on 25 May 2018 had a clear understanding of the duties of that role. Only Officers Sawhney and Denyer considered that part of the role involved periodically checking the CCTV screens in the Reception Area in order to monitor inmates in their cells.

13.9 The other officers who gave evidence, in particular Officer Bissett who was assigned the Monitor role at 6:00pm on 25 May 2018, did not consider this to be part of their duties, unless an inmate was on an ISP. Officer Bissett gave evidence that he had no recollection of how often (if at all) the Monitor was required to observe the CCTV screens. Indeed, Officer Bissett explained, "*I don't think [the screens] were ever really meant to be a [sic] monitoring, a person monitoring what was going on inside the cell. I think they were more about the recording of what was in the cell*".[13]

13.10 To put this evidence into stark perspective, Mr Osland gave evidence that he would be surprised to learn that as at May 2018, where no inmate was on an ISP, a number of officers working at the Surry Hills Complex had no understanding the need to make general observations of inmates by using the CCTV screens in the Reception Area. Mr Osland agreed that this absence of understanding was clearly contrary to what he had sought to convey regarding the responsibilities of the Monitor when this role was introduced.

[11] 3/11/20, T28.15-25.
[12] 3/11/20, T10.6.
[13] 4/11/20, T32.10-13.

13.11 **Conclusions:** It is clear that Mr Osland's expectations of the duties and responsibilities of the Monitor, when there was no inmate on an ISP, were not put into effect on 25 May 2018. Most of the officers on the C Watch did not consider that the duties of the Monitor were limited to the Reception Area, and also did not consider that there was any requirement for the Monitor to perform general observations of inmates in their cells by periodically checking the CCTV screens in the Reception Area. Relevantly, Officer Bissett, who was performing the Monitor role at the time of Mr Mavris' death, had an entirely contrary belief as to the intended use of the CCTV screens in this regard.

13.12 Therefore, whilst appropriate mechanisms were in place for Mr Mavris to have been effectively monitored on 25 May 2018, these mechanisms were not appropriately utilised due to a misapprehension as to the role of the Monitor. If any of the CSNSW officers on the A Watch had observed Mr Mavris actions in the periods between 11:50am and 1:40pm, and 6:10pm and 6:30pm on 25 May 2018, it is most likely that a mandatory notification would have been made in accordance with Section 3.7 of the COPP. This would have in turn resulted in Mr Mavris being placed on an ISP and being subjected to close observations at regular intervals.

13.13 Counsel for the Commissioner of CSNSW submitted that whether Ms Osland's expectations as to the Monitor role were sufficiently communicated or explicitly stated is a "*moot point*".[14] This is because, it is submitted, all CSNSW officers knew (or ought to have known) that they were under a duty to be vigilant (see further at [13.26] below). However, the general duty of a CSNSW officer to be vigilant cannot be said to entirely address an officer's precise role and responsibilities in a particular correctional setting.

13.14 Clearly, there is a need for the role of the Monitor, in circumstances where there is no inmate on an ISP at the Surry Hills Cells, to be explicitly stated and, in turn, clearly understood by the relevant CSNSW officer performing that role. The existing post duties and Local Operating Procedures contain no such explicit instructions. Therefore the following recommendation is necessary.

13.15 **Recommendation 1:** I recommend to the Commissioner of Corrective Services New South Wales that the post duties of the Monitor role at the Surry Hills Cells Complex, and the Local Operating Procedure 2019/04 *Generic duties and responsibilities of the Monitor Room Officer*, be amended to explicitly state that one of the responsibilities of the Monitor role is to regularly observe the CCTV footage of inmates in their cells for the purpose of identifying any behaviour that would give rise to a concern that an inmate is at risk of suicide or self-harm.

[14] Submissions on behalf of the Commissioner of CSNSW at [7].

13.16 One final matter regarding this issue should be noted. Counsel for the various CSNSW officers on duty during the C Watch made certain submissions regarding Mr ND's conduct on 25 May 2018 and the veracity of his evidence. To the extent that such submissions suggest that Mr ND is, or ought to be, exposed to some jeopardy pursuant to section 79 of the Act, the following should be made clear. That section does not provide the basis for a sufficiently interested party to make submissions regarding the possibility of referral pursuant to 78(4) of the Act. Rather, section 78(1)(b) provides the basis for certain procedural steps to be taken in relation to the conduct of an inquest if a coroner forms an opinion as to the likelihood of a known person being convicted of an indictable offence that is causally related to the death of the person who the inquest is concerned with. Its purpose in doing so is to preserve the rights of any such person of interest and the integrity of any consequent criminal proceedings, and to separate the role and functions of the coronial and criminal jurisdictions.

13.17 If an issue had arisen during the course of the inquest as to the possible enlivenment of section 78(1)(b) then, as a matter of procedural fairness, the opportunity to make submissions regarding this issue would only have been extended to any individual in potential jeopardy, and to Counsel Assisting. The opportunity for submissions to be made would not have been extended to any other party with sufficient interest in the inquest but that was not in jeopardy. This is on the basis that any party's right to be afforded procedural fairness could in no way be affected by whether section 78(1)(b) was enlivened or not. However, given that the available evidence does not enliven consideration of section 78(1)(b) the issue, and any submissions made regarding it, are immaterial.

13.18 For completeness, if the submissions made in this regard suggests that Mr ND had some moral obligation to respond to Mr Mavris' actions, then the following should be noted. It is accepted, as submitted by counsel for the Commissioner of CSNSW, that it is standard practice for an inmate considered to be at risk to be placed in "two-out" cell with another inmate, who may report matters of concern regarding an inmate's welfare to CSNSW officers. However, there is no evidence that any of the CSNSW officers on duty during the C Watch gave any consideration to Mr ND having some role in this regard. Further, any submission which might suggest that the presence of Mr ND in Mr Mavris' cell in some way abrogated the duty of care of all CSNSW officers in relation to inmates, and their duty to remain vigilant at all times, ought to be rejected.

Quality of the CCTV footage

13.19 Related to the role of the Monitor is the issue of whether the quality of the footage that could be viewed (or not) on the CCTV screens allowed a CSNSW officer to perform effective observations of inmates in their cells. In this regard there was conflicting evidence as to the quality of such footage:

(a) AS Yarnton gave evidence that the quality of the CCTV footage was variable, and that inmates had a tendency to impair the functionality of the CCTV cameras (by, for example, throwing toilet paper or water over the cameras) which in turn adversely affected the quality of the footage;

(b) Officer Sellman gave evidence that following lights out at 6:00pm "nothing" could be seen on the CCTV screens;[15]

(c) Officer Bissett gave evidence that because the CCTV screens were divided into nine smaller images it was difficult to discern what was occurring in an individual cell, and that after lights out it was difficult to discern anything "*on some cameras*";[16]

(d) Officer Walker gave evidence that generally speaking movement could be seen within a "*majority of the cells*" whilst *"[s]ome cells were very tough to see*" after lights out, and that the use of night vision cameras would be of assistance in this regard;[17]

(e) Officer Sawhney gave evidence that, depending on whether a CCTV camera had been tampered with, the CCTV, "*some of the cells are really good with the cameras, some of them are not really good*";[18]

(f) AS Searle also gave evidence of variable quality in CCTV footage with "good vision" in some cells, some cells not being ideal but with vision possible, and some cells (including Cell 20) being "*terrible when the lights are off*".[19]

13.20 It is clear that caution needs to be exercised when considering the extent to which self-serving statements by some of the CSNSW officers who gave evidence can be used in order to reach any conclusion as to the quality of footage that was viewable on the CCTV screens on 25 May 2018. Further, the evidence given by each of the officers is of little weight given that none were looking at the footage on the relevant CCTV screen at the time that Mr Mavris made preparatory acts to commit, and then committed, self-harm.

13.21 Regrettably, there is limited objective evidence available to allow for a definitive conclusion to be reached. It should be noted that as part of the CSNSW investigation, Graham Kemp, a CSNSW investigator conducted a "re-enactment" test in the early hours of the morning on 26 May 2018. This test involved Mr Kemp standing inside Cell 20 whilst a colleague took a photo using a mobile phone of the relevant CCTV screen in the Reception Area. However, it should be noted that there are certain limitations with the test performed by Mr Kemp, namely the quality of the mobile phone camera used to take the photo, the fact that the photo was digitally magnified and the fact that Mr Kemp was not standing in the exact location where Mr Mavris was found following the knock up call. It is acknowledged that Mr Kemp's colleague told him that she was unable to see him inside Cell 20 when she herself looked (without using a mobile phone) at the relevant CCTV screen. However, this is contrasted against a still image of the interior of Cell 20 which appears to show the location where Mr Mavris was found unresponsive to be illuminated and visible.

[15] 3/11/20, T78.38.
[16] 4/11/20, T41.20.
[17] 4/11/20, T76.15-31.
[18] 5/11/20, T8.34-35.
[19] 5/11/20, T42.6-20.

13.22 **Conclusions:** The evidence given by the various CSNSW officers indicates that apparent poor quality CCTV footage was most often associated with the period after when lights in the cells were turned off. This tends to suggest that Mr Mavris' actions in the period between 11:50am and 1:40pm on 25 May 2018 was most likely visible if observations had been made of the relevant CCTV screen.

13.23 Counsel for the various CSNSW officers on duty during the C Watch submitted that it would be reasonable for an officer to expect that an inmate who had requested that the lights in their cell be turned off would go to sleep, and not be likely to embark upon a course of action with intention to self-harm. However, no support for such a submission can be found in the CESU Standard Operating Procedures (**CESU SOP**) which contains no such qualifying provision. Further, such a submission is entirely consistent with a CSNSW officer's duty to be vigilant at all times (see [13.26] below). Finally, if a CSNSW officer were to unreservedly base the performance of their duties upon such an assumption, it would detract from the need to for that officer to critically assess any self-report made by an inmate as to their mental wellbeing.

13.24 Whilst the issue of whether Mr Mavris' subsequent actions in the period between 6:10pm and 6:30pm is not without doubt, it is most likely that enough of Mr Mavris' actions would have been visible to any officer performing a proper observation of the CCTV screens in order to trigger a mandatory notification. This is because the objective evidence of the still images from Cell 20, even accepting the associated limitations, suggests that the location in the cell where Mr Mavris was found unresponsive was illuminated so as to make his actions at least partially visible. Notwithstanding, the variable evidence given by the CSNSW officers as to the quality of the CCTV footage of the cells indicates that the following recommendation is necessary.

13.25 **Recommendation 2:** I recommend to the Commissioner of Corrective Services New South Wales that consideration be given to an urgent review of the CCTV cameras in the cells and the display screens in the reception area within the Surry Hills Cells Complex in order to determine (a) whether the CCTV footage is of sufficient quality to allow a correctional officer to identify any inmate behaviour that would give rise to a concern that an inmate is at risk of suicide or self-harm at all times; and (b) whether there is a need to implement a Local Operating Procedure in relation to the timing and circumstances in which cell lights are turned off, and the extent to which the absence of lighting in cells adversely impacts on the quality of CCTV footage.

Watching of television by CSNSW officers whilst on duty

13.26 Part 1 of the CESU SOP sets out a mission statement and the legal duty of care of all CSNSW officers in relation to inmates held in lawful custody. Further, Part 1 reproduces in part clause 252 of the *Crimes (Administration of Sentences) Regulation 2014* (**the Regulation**) which relevantly provides:

> ***Vigilance***
>
> *A correctional officer on duty must at all times devote the whole of his or her attention to the performance of his or her duties.*

A correctional officer must not do anything that is calculated to distract another correctional officer from the performance of the officer's duties.

13.27 Part 1 goes on to provide the following:

"*Supervising officers are to ensure that the vigilance of correctional officers is not distracted by watching television or any activity that would compromise their ability to maintain optimum vigilance and security awareness. Control room monitors are not to be used for any activity other than security surveillance.*

Television units for staff are allowable in the staff amenities and areas of correctional centres/court cells for out of hour's [sic] access only. Whilst on duty (including crib breaks) Correctional Officers are not [sic] access television units in the staff amenities areas or other areas of a correctional centres [sic]/court cells [sic]".

13.28 CCTV footage of the Reception Area between 6:07pm and 6:30pm shows Officers Bissett and Walker seated and watching television on one of the CCTV screens. Officer Walker watched the TV while eating his evening meal. Officer Bissett also sat watching TV with his feet up on a chair. It is evident from any fair and reasonable viewing of the CCTV footage of the Reception Area that the gaze of each officer remained on the television throughout this period.

13.29 AS Yarnton was asked in evidence, as one of the OICs of the Surry Hills Cells, whether he had raised the permissibility of watching television during a shift with other CSNSW officers. He explained: "*Look, TVs are being watched I think as long as Corrective Services has been operating. Obviously there's certain points and certain times that if you were going to flick the TV on that you shouldn't and there's other times when you think, well, there's nothing happening, we have no inmates, we have no prisoners, yeah, we can turn it on*".[20]

13.30 AS Yarnton agreed that, having regard to his supervisory position, he set expectations for other CSNSW officers throughout each watch. However, as to the question of watching television, AS Yarnton said: "*We, we, we all know what's right and what's wrong, at the end of the day. We all know what's right and what's wrong. I can't be there 24 hours a day. If they choose to turn the TV on when I'm not there, yeah, I can't do much about it, but if I'm on and I turn the TV on, well, then, obviously then I turned the TV on*".[21] AS Yarnton agreed that if he made a decision to turn the television on during a shift then he "*owned*" that decision.[22]

13.31 Notwithstanding AS Yarnton's awareness of the relevant provisions of clause 252 and Part 1 of the CESU SOP, he did not consider that the watching of television diminished the vigilance of CSNSW officers.[23] Indeed, AS Yarnton considered that (apart from a television located in a staff kitchen area) it was acceptable for CSNSW officers to watch television on one of the four CCTV screens if they considered that it was safe to do so.[24] AS Yarnton also frankly conceded that he took an

[20] 2/11/20, T63.16-20.
[21] 2/11/20, T63.31-35.
[22] 2/11/20, T63.38.
[23] 2/11/20, T63.43.
[24] 2/11/20, T67.5.

approach that it was contrary to the CESU SOP, and that he did not raise this approach with any person in a position of greater seniority.[25]

13.32 None of the CSNSW officers on the C Watch on 25 May 2018 were aware that the CESU SOP expressly prohibited the watching of television. However, each of the officers was well aware of the provisions of clause 252 of the Regulation. Notwithstanding, the officers gave differing evidence as to the permissibility of watching television in the Reception Area whilst on duty, and whether this has the potential to distract another officer from the performance of their duties:

(a) Officer Bissett gave evidence that he had previously discussed the watching of television whilst on duty with both AS Yarnton and AS Searle, both of whom indicated that doing so was permissible. Officer Bissett was asked whether he had ever sought guidance as to when during a shift the watching of television was permissible. He gave evidence that "*[u]sually it would be when officers, it's around when they're having their meal break and instead of sitting out in the meal room where they're isolated, they will sit in the reception room to assist other officers that are working, while they have their meal break, to watch the news or something like that*".

Although Officer Bissett understood that watching television whilst on duty was contrary to CSNSW policy he did not consider that doing so distracted from the performance of his duties. When asked why this was the case, he explained: "*Because I wasn't concerned about watching TV, I was actually sitting where the monitor and the phone was answering phone calls, answering knock-ups and also still looking at the monitors and no way did I, no way was I distracted from doing my duties at all*".[26]

(b) Officer Walker similarly understood that the watching of television during a shift was contrary to CSNSW policy. He said that he had never had a discussion with either AS Yarnton or AS Searle regarding the watching of television in the Reception Area. Officer Walker indicated that he changed the screen over to television on 25 May 2018 so that he could "*catch up on the local news*" while eating his evening meal, which he usually ate in the Reception Area.[27]

Initially Officer Walker gave evidence that he did not consider that having the television on distracted Officer Bissett or any other officer in the Reception Area. He said: "*I don't think I would've been distracting any officer, it was just myself was watching at the time I believe. I'd have to ask Neil if he, I don't know, but I don't believe I would've, as I said that was just a thing that I did while I was eating and I don't know. It wouldn't have stopped anybody doing their duties I don't believe*".[28] However later in his evidence, officer Walker agreed (after being shown the CCTV footage of the Reception Area depicting Officer Bissett reclining in a chair, with his feet up on the chair, and appearing to be watching television) that Officer Bissett was not performing his duties with the vigilance that was required.[29]

[25] 2/11/20, T67.38-43.
[26] 4/11/20, T36.32-35.
[27] 4/11/20, T80.3.
[28] 4/11/20, T81.9-13.
[29] 4/11/20, T88.16.

(c) Officer Searle gave evidence that the practice of watching television in the Reception Area began when the CCTV screens were first installed, which he believed was sometime in about 2017.

(d) Notwithstanding the views of AS Yarnton and Officers Bissett and Walker, Officer Sawhney indicated that whilst he was aware of the impermissibility of watching television whilst on duty, he considered this to be common sense. He explained: "*[Y]ou are in an environment where you shouldn't be watching TV. It is not allowed, there is a protocol in place to say this, but it is common sense too that you don't turn it on. You don't turn a monitor on to a TV*".[30]

13.33 Mr Osland acknowledged that historically there had been issues with CSNSW officers watching television whilst on shift. It is for precisely this reason that this issue was addressed at the forefront of the CESU SOP. Indeed this issue had also been addressed in previous versions of the SOP which also provided that the watching of television by CSNSW officers whilst on shift was impermissible.

13.34 Given AS Yarnton's attitude to the watching of television whilst on duty, and his practice of allowing it to occur, it is unsurprising that other CSNSW officers did not give consideration to whether such a practice adversely impacted upon their duty of vigilance, or whether such a practice ought to cease. Mr Osland gave evidence that it was the obligation of all CSNSW officers to report (anonymously) any concerns with such a practice to personnel within the CSNSW professional branch. Whilst Mr Osland expressed a hope that such reporting would occur, he also acknowledged the "*complexities and challenges*" surrounding the issue in circumstances where there had effectively been passive endorsement of the practice by senior officers such as AS Yarnton.[31]

13.35 The challenges and complexity is described by Mr Osland is perhaps best illustrated by the fact that even though Officer Sawhney held a supervisory role as 2IC during the C Watch shift on 25 May 2018, he did not consider that he had an obligation to challenge the practice of watching television whilst on shift. Indeed Officer Sawhney described in this way: "*[T]here is an OIC who is above me on the shift. And I feel that it is insubordination on my part to - if the OIC is there it is insubordination on my part to tell [other CSNSW officers] what to do*".[32]

13.36 Since Mr Mavris' death the ability to change the CCTV screens from displaying CCTV footage from the cells to television has been removed. This was done by removing an aerial cable that had been connected to one of the four CCTV screens. However, Officer Bissett gave evidence that within the Reception Area, on the wall opposite to where the four CCTV screens are located, is another screen that is used to monitor trucks delivering inmates to the Surry Hills Cells (**the Truck screen**). AS Searle gave evidence that when the aerial cable from one of the four CCTV screens was removed it was simply reconnected to the Truck screen. Officer Bissett gave evidence that since the death of Mr Mavris the Truck screen was still occasionally used to watch television.[33] Indeed, AS Searle gave evidence that the aerial cable to the Truck screen was only disconnected one to two weeks before

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[30] 5/11/20, T12.19-22.
[31] 6/11/20, T132.12-T133.7.
[32] 5/11/20, T12.29-31
[33] 4/11/20, T42.15.

the commencement of the inquest on 2 November 2020, and that the Truck screen had been used to watch television from May 2018 up until the time of this disconnection.[34]

13.37 **Conclusions:** On 25 May 2018 the conversion of one of the CCTV screens in the Reception Area to television by Officer Walker, and the subsequent watching of television by Officers Walker and Bissett was clearly contrary to the CESU SOP. Indeed, such a practice also arguably defied common sense, particularly when regard is had to the provisions of clause 252 of the Regulation.

13.38 However, the evidence established that this occurrence was not an uncommon one within the Reception Area. Indeed, it was a practice that was, if not endorsed by AS Yarnton, at least countenanced by him. This appears to have been due to a prevailing culture within the Surry Hills Cells (and indeed, possibly, within CSNSW more broadly) that the watching of television whilst on duty, especially during periods of inactivity over the course of a shift, was permissible and a matter for an individual officer to exercise their own judgement.

13.39 Counsel for AS Yarnton submitted that regard should be had to Part 1 of the CESU SOP which prohibits CSNSW officers from watching TV even whilst on crib breaks, and even in a staff amenities area such as a staff kitchen. Such a prohibition, it is submitted, is unreasonable and prone to encourage the watching of television whilst on duty in the Reception Area. To the extent that such a submission touches upon occupational health and safety, and employment conditions, that is a matter which falls outside the scope of an inquest. Notwithstanding, the evidence establishes that the practice of watching television in the Reception Area whilst on duty was one borne of convenience and a (mistaken) belief that doing so would not be a distraction, rather than from any prohibition of watching television in the staff kitchen.

13.40 Counsel for AS Yarnton also submitted that as CSNSW officers are prohibited from having mobile phones in the workplace, "*often their only communication with the outside world is by reference to news reports on television*".[35] If such a submission is intended in some way to justify the watching of television by a CSNSW officer whilst on duty then it cannot be accepted. An observation that a CSNSW officer is not employed to watch television whilst on duty, and that having no "*communication with the outside world*" over the course of an 8-hour shift could hardly be said to be onerous, is so self-evident as to be almost superfluous.

13.41 Some of the CSNSW officers who gave evidence expressed either reluctance or ambivalence in accepting that the watching of television whilst on duty was at odds with the need for vigilance in the performance of their duties, or that such a practice had the potential for distraction. However the CCTV footage of the Reception Area on 25 May 2018 shows Officers Bissett and Walker watching television from 6:14pm until 6:37pm. This is clearly a significant period of time and not a situation, for example, where the television might simply have been on in the background whilst the officers continued performing their duties.

[34] 5/11/20, T67.26-34.
[35] Submissions on behalf of the various CSNSW officers on duty during the C Watch at page 2.

13.42 Indeed, it should be remembered that the watching of television only ceased because of the knock up call made by Mr ND regarding Mr Mavris' emergency situation. In such circumstances, it is difficult to accept that the watching of television did not detract from the officers' duty of vigilance. This is so, even in circumstances where it was considered that no officer (and in particular Officer Bissett, who was performing the Monitor role) was required to use the CCTV screens to make observations of the inmates in the cells.

13.43 It is concerning that despite the events of 25 May 2018, and the removal of the ability to watch television on the four CCTV screens in the Reception Area, the ability to still watch television on the Truck screen remained up until shortly before the inquest commenced on 2 November 2020 when the aerial cable to the Truck screen was disconnected. Precisely what prompted this disconnection remains unclear on the available evidence, but it is perhaps not entirely coincidental that a pre-hearing scene view took place at the Surry Hills Cells on 30 October 2020. During the period of some 29 months that the Truck screen remained connected to the aerial it was used by CSNSW officers to watch television whilst on duty. This demonstrates either that there has been no appropriate consideration given to the circumstances surrounding Mr Mavris' death, or that CSNSW officers working at the Surry Hills Cells have not been provide with appropriate training as to the impermissibility of watching television whilst on duty, or both. Therefore, the following recommendation is necessary.

13.44 **Recommendation 3:** I recommend to the Commissioner of Corrective Services New South Wales that (a) CSNSW officers rostered on duty at the Surry Hills Cells Complex be provided with appropriate training regarding Part 1 of the Court Escort Security Unit Standard Operating Procedures relevant to the impermissibility of watching television whilst on duty; and (b) periodic audits be conducted by the General Manager, Court Escort Security Unit to ensure compliance with the provisions of Part 1 of the Court Escort Security Unit Standard Operating Procedures.

13.45 The evidence given during the inquest has raised concerns regarding the conduct of AS Yarnton in two respects. Firstly, the watching of television was countenanced by AS Yarnton in a supervisory role, both as part of own practice and by leaving the matter to an individual officer's discretion rather than applying the policy set out in the CESU SOP. Secondly, the intended duties and responsibilities of the Monitor role were not performed as intended due to AS Yarnton's personal attitudes regarding the utility and purpose of the role. For these reasons, the following recommendation is necessary.

13.46 **Recommendation 4:** I recommend to the Commissioner of Corrective Services New South Wales that the conduct of Assistant Superintendent Dean Yarnton be reviewed for possible disciplinary action in relation to (a) countenancing a practice of subordinate officers watching television whilst on duty at the Surry Hills Cells Complex, including after 25 May 2018; and (b) not utilising the Monitor role for its intended purpose.

13.47 Counsel for AS Yarnton submitted that such a recommendation ought not to be made because the watching of television by other CSNSW officers on 25 May 2018 "*did not result in a failure of any Officer to view events occurring around that time in the [sic] Cell 20*", due to the fact that whilst CCTV footage of Cell 20 remained on display it contained limited or no visibility, and Mr Mavris was not subject to an ISP which required close monitoring.[36] However, it remains the case that the watching of television between 6:14 and 6:37pm on 25 May 2018 significantly detracted from any opportunity by a CSNSW officer to observe the actions that Mr Mavris was engaged in to commit self-harm. Further, it was submitted by counsel for AS Yarnton that there was an established practice of CSNSW officers watching television whilst on duty, and that such a practice occurred even when AS Yarnton was not on duty. Whilst there is no factual dispute as to this submission, part of AS Yarnton's role as a supervisor was to reduce the likelihood of such a practice occurring. Instead, AS Yarnton's passive endorsement of the practice facilitated its occurrence.

Use of the Morseman Wand

13.48 As at May 2018 AS Yarnton was aware of the Morseman SOP. However he gave evidence of having no expectation that the terms of the Morseman SOP would be complied with by any officers under his supervision. As to the Head Check document which he authored, AS Yarnton described it as a "*local document*" and explained: "*I've put out a document that says how, how often I want it done and obviously [the Morseman SOP] tells you another thing, doesn't it?*".[37]

13.49 AS Yarnton was asked whether he turned his mind to the fact that the Head Check document was providing instructions to officers that were contrary to the Morseman SOP. AS Yarnton described the Surry Hills as a "*complex place*" where CSNSW officers were "*in and out of those cells all day long*" attending to a variety of duties such as feeding inmates, taking inmates to showers, facilitating the attendance of Justice Health nurses for medication rounds, and taking inmates to legal and welfare appointments.[38]

13.50 Despite AS Yarnton's views regarding the utility of the Morseman SOP, documentary records indicate that the Morseman Wand was activated at the docking port outside Cell 20 at 6:45am and 6:46am on 25 May 2018, and not again at any point up to when Mr Mavris was found unresponsive in his cell. Indeed, the records also demonstrate that the Morseman Wand was not activated at any docking port at the Surry Hills Cells at any stage between 1:01pm on 24 May 2018 and 11:59pm on 26 May 2018.

13.51 None of the CSNSW officers on the C Watch on 25 May 2018 who gave evidence were aware of the Morseman SOP. Further the CESU SOP makes no reference to the use of the Morseman Wand. Mr Osland gave evidence that the Morseman Wand was only used in two correctional settings (at the Surry Hills Cells and at Amber Laurel Correctional Centre in Emu Plains), and that the use of the Morseman Wand at the Surry Hills Cells dated back to 2009, before he became General Manager of the CESU. Mr Osland was also unfamiliar with the Head Check document or the practice of using the Morseman Wand when conducting head checks once during each A, B and C Watch.

[36] Submissions on behalf of the various CSNSW officers on duty during the C Watch at page 4.
[37] 2/11/20, T61.10-11.
[38] 2/11/20, T61.20-48.

13.52 Clause 4.6 of Section 3.7 of the COPP deals with observations that are to be made of inmates who are on an ISP. It provides that "*[a]ll inmates who are assessed as requiring physical with or without a Morseman Tool [sic] or electronic observations must be identified for each watch*".[39] Clause 4.6 goes on to provide that all physical and electronic observations, whether with the use of Morseman Wand or not, are to be recorded and detailed in a "*meaningful way*".[40] Therefore, these provisions in the COPP suggest that the use of the Morseman Wand is a discretionary matter when CSNSW officers are performing observations of inmates on an ISP. Mr Osland gave evidence that he did not "*necessarily link the use of a Morseman tool to the role and responsibilities of monitoring a person who was at risk*" and that the use of the tool is "*akin to more [sic] perimeter security corridors and security checkpoints*".[41] Mr Osland explained it in this way: "*If the Morseman tool is used on the perimeter to indicate that the roving officers have been active during the evening I support that process. It fits with the ethos of the Morseman tool*".[42]

13.53 **Conclusions:** The Morseman SOP contemplated more frequent and regular use of the Morseman Wand within the Surry Hills Cells than was actually occurring as at May 2018. Indeed, the terms of the Head Check document only provided for the use of the Morseman Wand three times every 24 hours, with two such uses occurring only 30 minutes apart (between 5:30am on the A Watch and 6:00am on the B Watch). Notwithstanding the significantly less frequent use of the Morseman Wand as stipulated by the Head Check document, actual records demonstrate that even these requirements were not being complied with; the Morseman Wand was not used at all in a 35 hour period from 1:01pm on 24 May 2018.

13.54 Whilst use of the Morseman Wand appears to be discretionary according to the COPP, it clearly contemplates the use of the Morseman Wand when CSNSW officers are performing observations of at-risk inmates who are on an ISP. There does not appear to be any basis for the Morseman Wand not being use simply because, according to AS Yarnton, CSNSW officers are performing other routine duties in the vicinity of cells during the course of a shift. The COPP clearly contemplates that observations of at-risk inmates are to be recorded and detailed in a meaningful way. A CSNSW officer merely performing an incidental observation whilst in the vicinity of a cell would appear to be inconsistent with inmate welfare in general, and contrary to the provisions of the COPP for inmates identified to be at risk in particular. Therefore, the following recommendation is necessary.

13.55 **Recommendation 5:** I recommend to the Commissioner of Corrective Services New South Wales that consideration be given to the implementation of a Local Operating Procedure for the Surry Hills Cells Complex which provides for (a) correctional officers to physically attend the cell of an inmate with sufficient frequency (for example, at least twice during each Watch) to ensure the safety and well-being of an inmate; and (b) that the Morseman Tour Guard Wand be used to confirm such attendances.

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[39] Exhibit 1, Tab 66, page 13.
[40] Exhibit 1, Tab 66, page 13.
[41] 6/11/20, T107.21-32.
[42] 6/11/20, T108.39-41.

14. Was the cell architecture at Surry Hills, particularly in relation to hanging points, appropriate?

14.1 As the Surry Hills Cells is located within the SPC aspects of cell architecture are the responsibility of the NSWPF. Prior to May 2018 there had been no review of the cell architecture at the Surry Hills Cells.

14.2 On 5 March 2019 a risk assessment team consisting of NSWPF and CSNSW staff conducted a health and safety risk assessment of the Surry Hills Cells. This assessment identified a number of risks, including hanging points, and methods to mitigate such risks. A completed health and safety risk assessment form was subsequently provided to the NSWPF Police Property Group so that works could be undertaken to rectify any areas that were deemed to pose a risk to an inmate's safety. Relevantly, the assessment identified that in individual cells (and shower areas) there were exposed bolts and gaps, together with poor welding on cell doors and frames. It was identified that such gaps could be used as potential hanging points. Accordingly as part of the remedial works undertaken, it was identified that the gaps in doors and frames needed to be filled with filler material that would not pose any further risk to inmates.

14.3 **Conclusions:** It is obvious that as at 25 May 2018 the cell architecture of individual cells at the Surry Hills Cells provided opportunities for inmates to self-harm. However, since that date appropriate steps have been taken by both NSWPF and CSNSW to investigate deficiencies in cell architecture. Further, appropriate remedial action has been conducted by the NSWPF to eliminate aspects of cell architecture that could contribute to an inmate committing self-harm in the same circumstances as Mr Mavris.

15. Materials available to inmates to create ligatures

15.1 Clause 5.7 of the CESU Standard Operating Procedure for *Inmate Bedding/Clothing Control* provides that "*[i]nmates held in 24hr cell complexes for an extended period of time will be issued a set of inmate clothing at the discretion of the OIC*".[43] No guidance is provided as to what constitutes an extended period of time, or what factors may be relevant to any exercise of discretion by an OIC.

15.2 AS Yarnton gave evidence that if Mr Mavris had been observed engaging in the type of behaviour that was recorded on the CCTV footage in the periods between 11:50am and 1:40pm, and 6:10pm and 6:30pm on 25 May 2018, then action would have been taken to limit his access to materials which could be used to self-harm. Specifically, this would have likely included providing Mr Mavris with only cardboard cutlery and dinnerware, and providing safe cell blankets which are manufactured in a way which prevents them being fashioned into a ligature.

[43] Exhibit 1, Tab 62, page 2.

15.3 **Conclusions:** If Mr Mavris had been adequately monitored in the periods between 11:50am and 1:40pm, and 6:10pm and 6:30pm on 25 May 2018, it is evident that a mandatory application would have been made, which in turn would have resulted in him being placed on an ISP. To further mitigate the risk of self-harm, it is most likely that any materials capable of being used to fashion a ligature would have been removed from him.

16. Keeping inmates at Surry Hills Cells for up to 72 hours before transfer to a correctional centre

16.1 Part 3 of the CESU SOP provides that "*[w]here possible all fresh custody inmates are to be moved to a correctional centre within 72hrs of reception from Court. No inmate sentenced or otherwise is to be held in excess of 72hrs without the express permission of the Assistant Commissioner, Security & Intelligence*".[44]

16.2 It is evident that Mr Mavris was in custody for approximately 40 hours prior to his death. After being refused bail, it is unclear whether any immediate steps have been taken to transfer Mr Mavris to a correctional centre ahead of his next court appearance.

16.3 **Conclusions:** At the time of his death there was no procedural or policy requirement for Mr Mavris to have been transferred from the Surry Hills Cells to a correctional centre prior to 6:30pm on 25 May 2018. More relevantly, and as noted above, if Mr Mavris had been adequately monitored in the periods between 11:50am and 1:40pm, and 6:10pm and 6:30pm on 25 May 2018, then it is most likely that he would have been placed in an ISP. This would have significantly mitigated any risk of self-harm, and decreased the possibility that the period of time that Mr Mavris spent in custody contributed to his death.

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

17.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Sophie Callan SC and Ms Juliet Curtin, Counsel Assisting, and their instructing solicitor, Mr Paul Armstrong of the NSW Crown Solicitor's Office. Their assistance during both the preparation for inquest, and the inquest itself, has been invaluable and of the highest standard. I also thank them for the sensitivity and empathy that they have shown in this matter.

17.2 I also thank Plain Clothes Senior Constable Tanya Oliver for her role as the officer in charge of the investigation, and for compiling a comprehensive initial brief of evidence.

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

Identity
The person who died was Dimitrios Mavris.

Date of death
Mr Mavris died on 25 May 2018.

[44] Exhibit 1, Tab 63, page 38.

Place of death

Mr Mavris died at the Surry Hills Cells Complex, Sydney Police Centre, Surry Hills NSW 2010.

Cause of death

The cause of Mr Mavris' death was hanging.

Manner of death

Mr Mavris died whilst in lawful custody, after having been refused bail, as a result of actions taken by him with the intention of ending his life.

18. Epilogue

18.1 It is truly distressing to know that all the loving memories that Mr Mavris' family have about his many positive qualities as a husband, father, uncle and friend also serve as a daily reminder of how greatly they miss him, and that they will no longer be able to enjoy and cherish simple everyday pleasures such as having dinner as a family together with Mr Mavris in his customary position at the head of the table.

18.2 On behalf of the Coroner's Court of New South Wales, I offer my deepest sympathies, and most sincere and respectful condolences, to DM, AM, NM and CM, and Mr Mavris' other family and friends for their most painful and overwhelming loss.

18.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
19 February 2021
Coroner's Court of New South Wales

Appendix A

Inquest into the death of Dimitrios Mavris

Recommendations made pursuant to section 82 *Coroners Act 2009*

To the Commissioner of Corrective Services New South Wales:

1. I recommend that the post duties of the Monitor role at the Surry Hills Cells Complex, and the Local Operating Procedure 2019/04 *Generic duties and responsibilities of the Monitor Room Officer*, be amended to explicitly state that one of the responsibilities of the Monitor role is to regularly observe the CCTV footage of inmates in their cells for the purpose of identifying any behaviour that would give rise to a concern that an inmate is at risk of suicide or self-harm.

2. I recommend that consideration be given to an urgent review of the CCTV cameras in the cells and the display screens in the reception area within the Surry Hills Cells Complex in order to determine (a) whether the CCTV footage is of sufficient quality to allow a correctional officer to identify any inmate behaviour that would give rise to a concern that an inmate is at risk of suicide or self-harm at all times; and (b) whether there is a need to implement a Local Operating Procedure in relation to the timing and circumstances in which cell lights are turned off, and the extent to which the absence of lighting in cells adversely impacts on the quality of CCTV footage.

3. I recommend that (a) Corrective Services New South Wales officers rostered on duty at the Surry Hills Cells Complex be provided with appropriate training regarding Part 1 of the Court Escort Security Unit Standard Operating Procedures relevant to the impermissibility of watching television whilst on duty; and (b) periodic audits be conducted by the General Manager, Court Escort Security Unit to ensure compliance with the provisions of Part 1 of the Court Escort Security Unit Standard Operating Procedures.

4. I recommend that the conduct of Assistant Superintendent Dean Yarnton be reviewed for possible disciplinary action in relation to (a) countenancing a practice of subordinate officers watching television whilst on duty at the Surry Hills Cells Complex, including after 25 May 2018; and (b) not utilising the Monitor role for its intended purpose.

5. I recommend that consideration be given to the implementation of a Local Operating Procedure for the Surry Hills Cells Complex which provides for (a) correctional officers to physically attend the cell of an inmate with sufficient frequency (for example, at least twice during each Watch) to ensure the safety and well-being of an inmate; and (b) that the Morseman Tour Guard Wand be used to confirm such attendances.

Magistrate Derek Lee
Deputy State Coroner
19 February 2021
Coroner's Court of New South Wales

Appendix B

Inquest into the death of Dimitrios Mavris

Non-publication orders

1. Pursuant to s.75(2)(b)(ii) of the *Coroners Act 2009* (the Act), that there be no publication of any matter (including the publication of any photograph or other pictorial representation) that identifies the Mr Mavris' wife and children as being relatives of the deceased.

2. Pursuant to s.75(4) of the Act, this order continues to have effect after the coroner has made his findings.

3. Pursuant to s.74(1)(b) of the Act, that there be no publication of any matter (including the publication of any photograph or other pictorial representation) that identifies the person that was in the same cell as the deceased at the time of his death.

4. Pursuant to section 74(1)(b) of the Act there is to be no publication of the following:

   (a) The documents identified in the appended Schedule to these Orders.

5. That any person who applies under section 65(2) of the Act for the provision of Corrective Services NSW documents that have been placed on the court file but have not been included in the tendered brief of evidence, shall not be provided that material until Corrective Services NSW has had an opportunity to make submissions in respect of the application.

Magistrate Derek Lee
Deputy State Coroner
19 February 2021
Coroner's Court of New South Wales

SCHEDULE TO NON PUBLICATION ORDERS	
Tab in Brief	**Document**
7A	**CSNSW Serious Incident Report 23 Jan 2019**: • Name/ MIN and any personal information of cellmate ND • Page 38/48 SOP Morseman Tour Guard , Para 51, 52 • Page 43/48- Para 64 words *'It is….shift'* • Page 46/48 – Paras 67,68,69 **Attachments Vol 1** • Attach 1- 11, 26 Name/ MIN and any personal information of cellmate 'ND' • Attach 1-11 Personal information (residential address) of deceased • Attach. 11 - Personal information of wife of deceased • Attach. 13 – names and MINS of inmates other than the deceased • Attach. 14 – names/ personal information of visitors to other inmates • Attach. 20 – Floor plan of SHCC • Attach. 23 – CSNSW Daily Employee Schedule and Roster • Attach. 24 – Morseman post duties • Attach. 27 – OIMS record for ND in total • Attach. 28, 29 – OIMS records for ND • Attach. 33 – Parole report for ND in total **Attachments Vol 2** • Attach. 1- CESU SOPS document in entirety • Attach. 2 – Surry Hills Police Cells current Post Duties entire • Attach 3 – Morseman Guard Headcheck D Yarnton • Attach. 4 – COPP 1.1 Reception Procedures – page 7, 8, 14,15, 16 phone numbers and contact emails • Attach. 5 – A Watch post duties - entire document • Attach. 6 – C Watch post duties – entire document • Attach. 7 – B Watch post duties – entire document • Attach. 8 – Surry Hill Cells Morseman Wand SOPS – entire document • Attach. 21 – Not for Inmate Release CESU SOP Bedding – entire document • Attach. 25 - COPP 13.3 Deaths in Custody – entire document • Attach. 26 – Interim Assessment report - References to name of cellmate ND, Page 2 - entire • Attach. 27 – COPP.13.8 – Crime Scene Preservation – entire document • Attach. 28 – References to name of cellmate ND
11A	CCTV footage of Cell 20 – 25 May 2018 – Annex A to Warren Searle Statement
16	Statement of Brian Denyer – Post duties attachment (see Tab 66)
21	Statement of Craig Osland: Annexure A. OIC A, B and C Watch post duties

	Annexure B. Control A, B and C Watch post duties Annexure C. Cells A, B and C Watch post duties Annexure D. CO AVL 1, 2 and 3 post duties Annexure E. Monitor A, B and C Watch post duties Annexure F. SCO A and C Watch post duties Annexure G. SCO AVL post duties Annexure H. 56+ and 76+ B, A and C Watch post duties Annexure I. 41+ B, A and C Watch post duties Annexure J. Generic duties and responsibilities of the monitor room officer Annexure K. Head Check and Morseman Check
61.	Standard Operating Procedures Morsewatchman Tour Guard
62.	Standard Operating Procedure – Court Escort Security Unit – 12 Sept 2017
63	Court Escort Security Unit – Standard Operating Procedures
64.	CSNSW Custodial Operations Policy and Procedure (COPP): Section 1.1 Reception Procedures (V 1.0)
65.	CSNSW Custodial Operations Policy and Procedure (COPP): Section 1.1 Reception Procedures (V 1.4)
66.	CSNSW Custodial Operations Policy and Procedure (COPP): Section 3.7 Management of inmates at risk of self-harm or suicide - version 1.0 (as at date of death)
67.	CSNSW Custodial Operations Policy and Procedure (COPP): Section 3.7 Management of inmates at risk of self-harm or suicide - version 1.2 (Current version)
68.	Documents referred to in Part 1.1 and Part 3.7 of the Custodial Operations Policy and Procedures: A. Inmate discipline checklist B. Inmate discipline decision: cover page C. Inmate interview questions to further evaluate risk D. Inmate undertaking to share accommodation

	E. ISP/RIT management plan observation record form F. ISP/RIT Management plan reference guide G. Mandatory notification for inmates at risk of suicide or self-harm – Part 1: Reason for mandatory notification H. Mandatory notification for inmates at risk of suicide or self-harm – Part 2: Immediate Support Plan I. Mandatory notification for inmates at risk of suicide or self-harm – Part 3: RIT Management Plan J. Mandatory notification for inmates at risk of suicide or self-harm – Part 4: RIT Discharge Plan K. Risk factors for consideration: reference guide L. RIT – assessment interview guidelines M. Suicide and self-harm: procedure checklist N. Suicide and self-harm: procedure checklist
69.	Training materials for "Awareness of safe custody online courselette" A. Art11-0041a – Why Safe Custody B. Art11-0042b – Initial Reception from Police-cells C. Art11-0443a – Screening and Assessment D. Art11-0044a – Managing at Risk Offenders E. Art11-0045a – Offender Transfers F. Art11-0057a – Role of the Coroner
70.	Training materials for "Awareness of managing at risk offenders online courselette" A. Art12-058b - Review of Deaths in Custody and Recent Inquiries B. Art12-059b - Self Harm and Suicide Considerations C. Art12-061b – Management of the At Risk Offender D. Art12-062b – Completion of the MNF E. Art12-063b – Completion of the IRM Justice
71	Surry Hills Floor Plan and Layout (Also in Investigation report attachment 20)
76	**CCTV footage and Audio Files** o CCTV footage appendage to statement of Mat Damaso Cell 1. Cell 20 o CCTV footage appendage to Statement of William Ellis (3.00pm – 8.00pm) o CCTV footage appendage to Statement of William Ellis (12.00am –

	4.30am) o CCTV footage appendage to Statement of Warren Searle (6.00pm - 7.30pm) o USB containing CCTV Footage of Cell 1 and CCTV Footage of Cell 20
	Exhibit 2