STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	**Inquest into the death of "MH"** [redacted]
Hearing dates:	8 - 11 March 2021
Date of findings:	15 July 2021
Place of findings:	Coroner's Court of NSW, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – death in custody – manner of death – chronic mental illness – adequacy of care
File number:	2017/188495
Representation:	**Counsel Assisting** Dr Peggy Dwyer, instructed by Ms Amber Doyle, NSW Crown Solicitor's Office **"RH"** [redacted] Ms Georgia Lewer of counsel, instructed by Mr Callum Hair, Legal Aid NSW **Commissioner of Corrective Services** Mr Patrick Broad, Solicitor Advocate, instructed by Valentino Musico, Department of Communities and Justice. **Justice Health and Forensic Mental Health Network** Mr Jake Harris of counsel, instructed by Ms Kate Hinchcliffe, Makinson d'Apice Lawyers **Frances Crown and Bronwyn Ford**

	Mr Steve Russell of counsel, instructed by Mr Dominic Longhurst, McNally Jones Staff Lawyers **Michael Harris** Ms Katherine Doust, NSW Nurses and Midwives Association **Dr Jeremy O'Dea** Mr Ben Bradley of counsel, instructed by Claudine Watson-Kyme, MDA National **Dr Shweta Sharma and Dr Usman Mohy-Ud-Din** Mr Cameron Jackson of counsel, instructed by Ms Francesca Davis, Avant Mutual
Non-publication order and non-access orders	Annexure A contains the details of non-publication and non-access orders and is available upon request from the Court registry

Findings:	Pursuant to s. 81(1) of the *Coroners Act 2009,* the following findings are recorded: **The identity of the deceased** The person who died was [redacted] **Date of death** 23 June 2017 **Place of death** Goulburn Correctional Centre, NSW **Cause of death** Hanging **Manner of death** Intentional self-inflicted death, likely precipitated by a mental illness episode.
Recommendation:	Pursuant to s. 82 of the *Coroners Act 2009,* the following recommendation is made: **To the CEO, Justice Health and Forensic Mental Health Network:** That consideration be given to developing health care plans for patients at Goulburn Correctional Centre who suffer from chronic and major mental health illness with such a health care plan being updated as necessary by the care coordinator/case manager and including, amongst other relevant matters: diagnosis, medication; cell placement; target frequency of review; early warning signs of deterioration or relapse; target interventions including metabolic monitoring, psychology, employment, other psychosocial supports; risk management and recovery plan; and, the wishes of the patient and family.

Table of Contents

Introduction

1. These are the findings of inquest into the death of [redacted], whom I shall refer to in these findings as "MH".

2. MH was only 22 years old when he died by hanging in his cell at Goulburn Correctional Centre ("Goulburn CC") on 23 June 2017. He was being held on remand, having been refused bail at Goulburn Local Court on 21 May 2017 and was due to next face court on 1 August 2017.

3. Immediately prior to his incarceration at Goulburn Correctional Centre, MH had been an inpatient at the Chisholm Ross Centre, a hospital based mental health facility. MH had struggled with mental health issues since his teenage years. His diagnosis, at the time of his death, was severe chronic schizophrenia with substance use disorder resistant to treatment.

4. In the preparation of these findings, I have been assisted by the written submissions of counsel assisting and the submissions of the legal representatives of the interested parties.

5. MH's mother, [redacted] "RH", attended each day of the inquest and her love for her son was evident. It was also evident that she went to extraordinary lengths to obtain care for her son and was a tireless and skilled advocate on his behalf. Also in attendance in Court were other members of MH's family, including his aunts [redacted] "B" and [redacted] "L", who alongside RH, tried so hard to help MH as he struggled throughout his tragically short life to deal with the impact of his illness. I extend my sincere condolences to RH and to the other members of MH's family.

The nature of an inquest

6. An inquest was required to be held because it appeared MH died whilst in lawful custody (s. 27(1)(b) and 23(1)(a) of the *Coroners Act 2009*).

7. The primary function of an inquest is to identify the circumstances in which the death occurred. At the conclusion of an inquest, the role of a coroner, as set out in s. 81 of the *Coroners Act 2009*, is to make findings where possible as to:

a. The identity of the deceased person;

b. The date and place of the person's death; and

c. The manner and cause of death.

8. A secondary purpose of an inquest is to consider whether it is "necessary or desirable" (s. 82) to make recommendations in relation to any matter connected with the death. This involves considering whether any lessons can be learned from the death, and whether anything should or could be done to prevent a death in similar circumstances in the future.

The Proceedings

9. The hearing of the inquest into MH's death was held at the Coroners Court of NSW in Lidcombe on 8 – 11 March 2021.

10. An issues list was distributed to parties identified as having a sufficient interest in the proceedings. The issues, in addition to the findings required by s. 81 of the *Coroners Act 2009*, were as follows:

    a. Whether MH's death was intentionally self-inflicted and/or was precipitated by a mental illness episode.

    b. The adequacy of the intake process at Goulburn Correctional Centre in May 2017, including as to the assessment of MH's risk of self-harm and steps to minimise that risk.

    c. Whether the monitoring and clinical management of MH was appropriate and otherwise in accordance with best practice in the context of MH's history of self-harm and diagnosis of chronic schizophrenia.

    d. The adequacy and appropriateness of communications between MH and CSNSW staff, in particular, communications conveying to MH on 21 June 2017 that his mother declined further contact.

    e. The effect, if any, on MH on the level of zuclopenthixol detected in his blood post mortem.

    f. Whether MH was appropriately housed at Goulburn Correctional Centre.

g. Whether all appropriate measures were taken to remove self-harm implements and hanging points from the cell occupied by MH.

h. Whether it was clinically appropriate that MH was discharged as an involuntary patient from the Chisholm Ross Centre.

i. Any recommendations necessary or desirable pursuant to s. 82 of the *Coroners Act 2009*.

Background of MH

Family Background

11. MH was born on 6 July 1995, to parents RH and [redacted]. MH's biological father was not involved in his upbringing. In raising MH, RH was greatly assisted by her mother and sisters. RH described her sister B as a "second mother" to MH and he lived with B during his teenage years.

12. It was during his teenage years that the symptoms of MH's illness began to emerge. This was a confusing and challenging time for MH and his family. MH was diagnosed with schizophrenia and was medicated for his illness. He then spent time as a resident in a number of mental health facilities. RH told of how, over the remaining years of MH's life, she would continue to seek out various treatment programs for MH.

13. Directly related to his mental health issue, MH struggled with drug addiction, and from time to time relapsed into drug use, which in turn adversely impacted on his mental health.

Criminal and Mental Health History

14. In March 2016, MH entered the custody of CSNSW for the first time in relation to breaching an apprehended violence order. He was released later the same day.

15. Between 16 March 2016 and 21 May 2017, MH had six short periods of custody. MH was held at the Queanbeyan Court Cells on two occasions and the remainder of the time at Goulburn CC, Parklea Correctional Centre and the Metropolitan Remand and Reception Centre ("MRRC").

16. On four of those occasions a Reception Screening Assessment ("RSA") was conducted by Justice Health nursing staff. MH's medical record discloses problematic substance use, a history of self-harm, behavioural issues, and medication non-compliance. The majority of his offences related to domestic violence and breach of apprehended violence orders.

17. MH was again detained in Queanbeyan Court Cells on 2 – 3 August 2016. A self-harm incident was recorded on 2 August 2016, however, the nature of that incident is unclear.

4 June 2016 – First admission to Goulburn Correctional Centre

18. On 4 June 2016, MH was taken to Queanbeyan Court Cells and later detained at Goulburn CC for about three weeks. Correctional Officer David Hall recorded that during the intake interview:

> "I asked him if he would self-harm in our custody and he replied 'how can I, I got nothing to cut myself with.'"

19. MH was seen by Dr Jeremy O'Dea on 14 June 2016. Dr O'Dea is an experienced forensic psychiatrist. He has worked the custodial setting since 1996. Since 2006, he has been contracted to provide approximately three psychiatric clinics each month to the Goulburn CC.

20. Dr O'Dea recorded the following in MH's medical record:

> "He presented with a blunted affect, disorganised thinking, limited rapport, and limited insight. He has been remanded to custody charged with breach of AVO and has been threatened by cellmates who claim he has been talking to them about the devil. He has also been observed by nursing staff to be responding to auditory hallucinations."

21. Dr O'Dea considered MH's diagnosis to be "severe chronic treatment resistant schizophrenia with evident negative syndrome complicated by substance use disorder." Dr O'Dea considered MH's symptoms to not be under adequate control and began the process to have him transferred to a secure psychiatric facility under the *Mental Health Act 2007*. However, before this could occur MH was released from custody and the referral lapsed.

November 2016 – Second admission to Goulburn Correctional Centre

22. MH was again admitted to Goulburn CC on 26 November 2016. He was charged with contravene apprehended domestic violence order ("ADVO"), destroy or damage property, and common assault.

23. On 27 November 2016, MH was served with a final domestic violence order in relation to his aunt L and was prohibited from going within 50 metres of her home. MH reported "I had a binge before being locked up". He reported recent use of alcohol, heroin, speed, ice and cannabis.

24. MH was medicated with Zuclopenthixol (Clopixol) an antipsychotic. He was released on 6 December 2016.

December 2016 – Third admission to Goulburn Correctional Centre

25. On 30 December 2016, MH was convicted of a number of offences. He was sentenced to bonds for common assault and destroying property and to a fixed term of seven months imprisonment for contravene ADVO.

26. MH was detained in Goulburn CC from 30 December 2016 to 27 March 2017.

27. On 3 March 2017, MH was found slumped inside a plastic tub, holding a pair of snips, having cut his own calf, forearm, and side of the throat. An incident report suggested that MH kept changing his story, from doing it to himself to alleging someone else had harmed him. CSNSW staff concluded that the wounds were self-inflicted.

28. MH was treated in the clinic and then placed in an observation cell. On 5 March 2017, MH was seen by the Risk Assessment Intervention Team ("RAIT") where he presented as settled and denied suicidal or self-harm ideation. He was discharged into a normal routine and normal cell placement.

29. On 20 March 2017, psychiatrist Dr Gordan Elliot provided a report to the Local Court, in preparation for a hearing on 27 March 2017. For the purposes of preparing his report Dr Elliot was provided with a statutory declaration from B who expressed her "despair about his persistent ill health and chaotic lifestyle".

30. Relevantly Dr Elliot opined:

- MH presented with ongoing auditory hallucinations and persistent delusional beliefs and mild formal thought disorder, consistent with a diagnosis of chronic schizophrenia;
- It would be unlikely he would currently be considered for admission to an inpatient unit.
- There were no reasonable grounds to believe MH was a mentally ill person within the meaning of the *Mental Health Act 2007*; and,
- MH fulfilled the criterial for a diversionary order under s. 32 of the *Mental Health (Forensic Provisions) Act 1990*. That order should include, amongst other conditions, that MH attend an initial psychiatric assessment … and dutifully attend all subsequent appointments".

31. Upon MH's release from custody, RH arranged to rent him a flat and equipped it with furniture and other essentials. Shortly thereafter, MH contacted Police and told them his neighbours were trying to kill him. Police took MH to hospital, however, he absconded from the emergency department because he believed the radio waves would kill him. RH met MH the next morning for breakfast and it was evident to RH that he was experiencing hallucinations and hearing voices. RH then contacted the Police.

Admission into Chisholm Ross Centre – 11 April 2017

32. On 11 April 2017, MH was brought by Police to the Chisholm Ross Centre, a mental health unit located at Goulburn Base Hospital. MH presented with an acute psychotic episode. His diagnosis was schizophrenia complicated by substance abuse and medication non-adherence. MH was admitted and scheduled as an involuntary patient under the *Mental Health Act 2007.*

33. MH was admitted under the care of Dr Shweta Sharma. At that time Dr Sharma worked only one day a week at Chisholm Ross, Fridays, and would personally interview MH each week.

34. Dr Sharma gave evidence that when she first saw MH on 13 April 2017, she considered him to be mentally ill for the purposes of the *Mental Health Act 2007*. Dr Sharma described MH's presentation as very guarded, very suspicious, and not very engaging in terms of verbal engagement. He looked very unwell, as if he were responding to internal stimuli and was very scared.

35. Dr Sharma received reports from nurses of bizarre behaviour in the form of looking suspiciously at the CCTV and talking about radiations from a microwave. She concluded that MH had ongoing psychosis in the form of persecution and bizarre delusions involving the CCTV, microwave radiations. He remained a risk to himself and others.

36. Dr Sharma commenced antipsychotic treatment in the form of Zuclopenthixol (Clopixol) and his dosage was increased from 300mg to 400mg administered weekly.

37. On 2 May 2017, MH was brought before the Mental Health Review Tribunal ("MHRT"). The MHRT determined MH was to be detained for five weeks with a further review on 30 May 2017. It was noted that he was to be assessed for rehabilitation for drugs and alcohol. Dr Sharma gave evidence that 30 May 2017 was the maximum period for which they were permitted to detain MH and the MHRT did not prescribe a minimum period of detention.

38. It took roughly a month to get MH's symptoms under control. In her statement, Dr Sharma said that MH's treating team had noted consistent improvement to his psychotic symptoms in the days (roughly a week) prior to his discharge.

39. A progress note made by Dr Sharma, on 19 May 2017, records:

> "MH was seen with Dr Chan, RMO … Had interview with Dooralong rehab services yesterday and he was positive that he will be accepted … He is on a CTO and has a high risk of relapse and non compliance. A stable accommodation will assist in assertive long term management post discharge. …
>
> Awaiting D & A rehab placement and stable accommodation.
>
> No leave, has ongoing tendencies to break the ward rules …
>
> He may be discharged on a depot once a suitable accommodation is found."

40. In Dr Sharma's view, MH's problem behaviours persisted despite minimal overt psychotic symptoms. The problem behaviours included rule breaking such as keeping mobile phone in the unit without permission and using illicit drugs in the unit. In Dr Sharma's opinion "this pattern is typically observed in patients with personality disorder which then contributes towards behavioural issues, regardless of mental illness."

41. In relation to the presence of negative symptoms, Dr Sharma told the court that "that is a symptom that can last almost forever which such level of illness that he had, and that doesn't actually contribute to the risk, so we do not use those negative symptoms as a reason to detain someone as mentally ill."

42. Dr Sharma accepted that MH's continuing use of illicit drugs was linked to his mental illness "indirectly." Dr Sharma told the Court:

> "It was getting more and more difficult as his psychotic symptoms were improving, because with improvement in his mental state he was entitled to have less restrictions, which means a little bit more time out of the hospital. He was quite young to have had that freedom, and when we tried that it ended up him bringing drugs into the unit and also managing to get drugs from other patients who were on leave when he was not granted leave. So it was getting harder and harder for us to put the restraints on him without having seen the direct delusions or hallucinations."

43. Dr Sharma said that she attributed MH's history of self-harm to direct psychotic symptoms that that he was very distressed with and that he would self-harm to avoid those symptoms.

44. On 20 May 2017, MH was charged with 'assault with an act of indecency' and 'common assault'. The allegation was that he assaulted a female patient by grabbing her and putting his whole right hand between her legs, pushing her against a wall. Following the alleged incident, Chisholm Ross staff contacted Police.

45. Dr Mohy-Ud-Din was the registrar on duty at Chisholm Ross on that date. He reviewed MH recorded and noted in MH's records:

> "No indication or evidence of psychotic illness the factor for last night incident & this seems to be behavioural (treating Psychiatrist also believes the same).

> NOTE: Dr Shweta Sharma (Psychiatrist) does not have any problem with police charging MH for last night's incident. Dr Sharma reports that MH has been getting away (*sic*) for a long time due to his Dx of Schizophrenia, but there is no current evidence of acute psychosis. MH is currently in CRC only because treating team was awaiting stable accommodation for him.
>
> Plan
>
> D/W Dr Shweta Sharma (Staff Specialist):
>
> …
>
> - Can be discharged to police custody as no evidence of acute psychosis at this stage
> - If police decides to release MH over the weekend, then to bring him back to CRC
> - If goes to prison or police custody, CTO will continue."

46. Dr Sharma explained that the reference to a CTO was in fact a reference to the mental health plan made on 2 May 2017.

47. Dr Sharma told the Court that the decision to charge MH was made by Police and not her. She agreed that it was possible that if Police had been informed that MH was mentally ill at the time of the incident that it may have made it less likely he would have been charged. However, because his symptoms were improving and staff had been noticing improvement in the preceding few days, they did not believe MH's mental state had any direct connection to the incident.

48. Ms Lewer put to Dr Sharma that as soon as it is thought that a person is no longer mentally ill there is an obligation to cease their involuntary detention. Dr Sharma answered:

> "You can use the Mental Health Act in so many different ways. He could not be let out in the community homeless just because he was no longer mentally ill for that legal definition. I had to keep him in the unit until I could discharge him safely."

49. Dr Sharma agreed that she considered that she could discharge MH safely on 20 May 2017 because she believed he was going to be held in prison and would continue to receive treatment.

50. Dr Sharma told the Court that she was aware that the treating team at Chisholm Ross had contacted RH about MH's pending discharge and that she had made

sure the family were aware. Asked by Ms Lewer whether she consulted with RH before determining to discharge MH, Dr Sharma said that this was "not a planned discharge with full usual obligations", there had been an assault on a patient in the unit and she did not wish to hinder the Police process.

51. MH was refused bail and entered the custody of CSNSW at Goulburn CC on 21 May 2017. He remained on remand until his death.

52. The reasons noted by Police for refusing bail include that MH's treating doctor told Police that MH was not mentally ill at the time of the alleged offending and that he was only a resident at the Chisholm Ross Centre as he had no stable accommodation.

53. Counsel Assisting submits that there is no proper basis to criticise Police for the bail decision. Police were alerted to a potentially serious sexual offence by staff at the Chisholm Ross Centre. MH had allegedly committed an offence whilst on parole and whilst subject to a good behaviour bond. Although a breach of parole report was not created, there was a proper basis for Police and the Magistrate to refuse bail. I accept that submission. It is not the role of this Court to go behind that decision making. Dr Sharma's role in the discharge of MH from the Chisholm Ross Centre is considered below.

Issue (h) - Whether it was clinically appropriate that MH was discharged as an involuntary patient from Chisholm Ross Centre

54. Counsel Assisting submits that whilst it appears that MH's psychotic symptoms did improve whilst he resided at the Chisholm Ross Centre, there were signs in the medical notes that some delusions persisted, and that his mood was labile. This was understandable in circumstances where MH continued to use illicit drugs. However, Counsel Assisting does not invite me to criticise the doctors involved in MH's care as they are required to make difficult decisions in an environment that is less than perfect, and to balance freedoms for a young person with an effort to treat patients.

55. Ms Lewer makes three broad submissions. First, that I should find that MH should not have been discharged from the Chisholm Ross Centre because this was not in accordance with the *Mental Health Act 2007* or best clinical practice and that

the decision to discharge MH contributed to his death. Ms Lewer submits there was no plan to discharge MH before he committed the alleged assault, and that if MH were not mentally ill for the purposes of the *Mental Health Act 2007,* he was being unlawfully held as an involuntary patient before discharge. Ms Lewer submits that the more compelling explanation is that MH remained a "mentally ill person" and that is why Dr Sharma instructed Police that if MH were to be released from custody he was to be returned to Chisholm Ross.

56. Secondly, Ms Lewer submits that Dr Sharma breached s. 79 of the *Mental Health Act 2007* in failing to consult with RH before MH's discharge from the Chisholm Ross Centre.

57. Thirdly, Ms Lewer submits that Dr Sharma failed to take any proper measures to endure MH would receive ongoing treatment of follow up.

58. Mr Jackson endorsed the submissions of Counsel Assisting and submitted that Ms Lewer's submissions fail to sufficiently acknowledge the challenges that complex patients like MH present.

Ms Lewer's first submission

59. I accept that the decision to discharge MH into the custody of Police, and subsequently to CSNSW, caused RH considerable pain and distress and that it continues to do so. MH was young and vulnerable due the nature of his illness. In circumstances where, it seems clear, MH's symptoms, to some degree, remained throughout his time at Chisholm Ross, it is, on one view, difficult to understand how it could have been appropriate for MH to be discharged from a treatment facility where he resided as involuntary patient, and taken to into custody, in circumstances where it was not known where and for how long he would be detained.

60. However, I accept the submission of Counsel Assisting that there is no basis to criticise the doctors involved in MH's care at Chisholm Ross. In doing so I give significant weight to the evidence of Dr Nielssen and Dr Sullivan who are well placed to provide an opinion on the way in which the *Mental Health Act 2007* is applied in practice.

61. Ms Lewer's submission that MH's discharge was contrary to the *Mental Health Act 2007* proceeds by the following logic. The *Mental Health Act 2007* requires that upon a clinician forming the view that a patient is no longer "mentally ill", that patient must immediately be released from involuntary detention. Accordingly, because MH remained detained as an inpatient at Chisholm Ross, it follows that I would find he was "mentally ill" and, accordingly, his discharge to Police custody was not in accordance with the *Mental Health Act 2007* or best clinical practice.

62. I do not accept Ms Lewer's submission since I do not consider the first plank of Ms Lewer's argument to be made out. The determination that a person is "mentally ill" for the purposes of the *Mental Health Act 2007* is a risk assessment. I accept that that risk assessment may be informed by the environment it was proposed that the patient was to be discharged to. This view is in accordance with the evidence of the experts that practitioners apply the relevant provisions of the *Mental Health Act 2007* with a degree of flexibility.

63. Counsel Assisting asked Dr Nielssen and Dr Sullivan whether they had experience with the *Mental Health Act 2007* being applied somewhat flexibly to ensure a person is not discharged from a ward into unsafe circumstances. Dr Sullivan told the Court:

> "All clinicians are faced with the same conflict, the conflict to ensure that they follow the letter of the law and the tension between doing that and ensuring that they do the right thing for patients, so in a situation where a person has a chronic relapsing mental illness, even when they appear well on a cross-sectional interview, I think most clinicians would be satisfied that, longitudinally, and in the short term, that person would be likely to show evidence sufficient to satisfy the Mental Health Act, and I think they would in good faith maintain a person there rather than immediately discharge them because they saw the criteria were not satisfied. So for a clinician, although bound by the law, the clinician is also bound by their clinical perspectives on the patient at a particular time."

64. Dr Nielssen agreed with Dr Sullivan and added:

> "There is an obligation not to discharge a person without having made proper arrangements, for example, or without having some concern about what will happen

after they are discharged. So again, those decisions were perfectly within the meaning and spirit of the law."

65. Dr Nielssen and Dr Sullivan both accept, contrary to Ms Lewer's submission, that continuing to hold a patient in involuntary detention in circumstances where they may appear well, as Dr Sharma indicated she did, may be justified when consideration is given to the harm that might arise from discharge to a particular environment such as discharge to homelessness. I do not accept MH was being held unlawfully, and accordingly, do not accept that because unlawful detention would be unlikely it must follow that MH was mentally unwell when discharged rendering his discharge contrary to the *Mental Health Act 2007*.

66. Further, I am not persuaded that there was no plan to discharge MH prior to the incident on 20 May 2017. Review of MH's medical record reveals repeated references to attempts to obtain accommodation for MH. The note made by Dr Sharma on 19 May 2017, extracted earlier in these findings, expressly states that MH was awaiting a drug and alcohol rehabilitation placement and stable accommodation, and that MH could be discharged on a depot once suitable accommodation was found.

67. In circumstances where I have not found that MH should not have been discharged from the Chisholm Ross Centre, I do not consider it necessary to deal in detail with the submission that MH's discharge contributed to his death. In any event, I do not consider that, given the passage of time between MH's discharge and his death, and the complexities of MH's condition generally, such a finding is open.

Ms Lewer's second submission

68. I do not accept that any failure to consult with a person's designated carer prior to discharge constitutes a breach of the *Mental Health Act 2007*. Section 79(1) requires the taking of "all reasonably practicable steps" to ensure a patient's designated carer is "consulted in relation to planning the patient's or person's discharge".

69. Dr Sharma's evidence was that MH's discharge from Chisholm Ross Centre was not planned. Significantly, in my view, the catalyst for his discharge was the

report received by staff that MH has assaulted a fellow patient. That allegation was serious and had a sexual component. I have great sympathy for MH and his vulnerability, but I am not critical of the decision to report the allegation to Police in the context of the duty of care owed by the Chisholm Ross Centre to its patients, some of whom reside in that facility involuntarily, and some, if not many, would be regarded as vulnerable persons. Once the allegation was reported to police it set in train a process which was, to some extent, outside of Dr Sharma's control. Dr Sharma's evidence was that she did take steps to ensure RH was notified of the pending discharge.

70. While I appreciate the circumstances in which MH was discharged from the Chisholm Ross Centre were well short of ideal, and that this quite understandably caused MH's family distress, I am unable to accept that, in the circumstances, any failure by Dr Sharma to consult with RH in advance of the discharge constituted a breach of the *Mental Health Act 2007*.

Ms Lewer's third submission

71. With respect to whether there were sufficient plans in place for MH's ongoing care this must, in my view, be considered in the context of the events leading to MH's discharge, being the allegation made against him. Dr Sharma told the Court that she expected MH to be held in custody and that, accordingly, he would continue to receive treatment. Dr Sharma also gave evidence that Police were instructed to return MH to the Chisholm Ross Centre in the event he was released from custody. This evidence is supported by notes made in MH's medical record. Dr Sharma's evidence was that in circumstances where MH would be on the street, homeless, and with access to drugs, she would have considered that MH could have been detained under the *Mental Health Act 2007* because of the risks associated with that environment. In the context of the unplanned nature of MH's discharge and the circumstances surrounding it, I do not consider that Dr Sharma failed to take any proper measures to ensure MH would receive appropriate ongoing treatment or follow up.

Admission into Goulburn Correctional Centre

21 May 2017 – Reception and Justice Health Screening

72. On 21 May 2017, MH was received into CSNSW custody at Goulburn CC. When screened at reception MH was asked whether he had previously attempted suicide or self-harm to which MH answered "Four years ago. Hanging". MH was also asked if he had received psychological or psychiatric treatment to which he replied "Arrested while in Chisholm Ross Centre. Schizophrenia Injection Clybixec". MH was not recorded as being at risk of self-harm or suicide.

73. On 21 May 2017, MH was seen by Registered Nurse Narelle McLaren, a primary care nurse employed by Justice Health. RN McLaren recorded the following note in MH's medical record:

> "New reception from Goulburn Court this PM. Previous gaol history; stated released from Chisholm Ross Centre yesterday and is on IM depot and meds for history of schizophrenia. Release of Information signed. Denies suicidal ideation or intent. HPNF completed. Placed on mental health waitlist. Denies any medical history. Nil issues or complaints voiced."

74. RN McLaren completed a Reception Screening Assessment. This assessment is undertaken for every inmate when they enter Goulburn CC and takes about 20 minutes to one hour to complete.

75. MH reported no medical issues and denied drug or alcohol use in the preceding four weeks. MH stated that he had been discharged the day before from the Chisholm Ross Centre and indicated he had schizophrenia.

76. RN McLaren assessed MH using the Kessler Psychological Distress Scale which measures psychological distress. MH scored 13 out of 50 giving a result of "likely to be well". RN McLaren recorded that MH presented with "blunted affect, normal behaviour during interview, good insight into current custody. Denies suicidal ideation or intent."

77. MH denied having ever tried to hurt himself and denied that there was anything causing him concern. RN McLaren determined MH was not at immediate risk of self harm or suicide.

78. RN McLaren did not have access to any records which showed that, contrary to what MH told her, he had previously tried to self harm. However, RN McLaren told the Court that even if she had been aware of this information it would not have changed her assessment or recommendation for placement, which was based on his presentation at the time of assessment.

79. RN McLaren had MH sign a release of information to obtain his records from the Chisholm Ross Centre. Those records arrived on 23 May 2017.

80. RN McLaren placed MH on the waitlist to be seen by the mental health team and allocated him a priority of '2' which she understood required him to be seen within 24 hours. At that time, however, a priority of '2' required a patient to be seen within 3 – 7 days. RN McLaren allocated him that category as:

> "he had been just discharged the day before from Chisholm Ross and then he had a history of schizophrenia and I wanted him seen because he was on depots and everything and I wanted the medication ordered and everything, so that's why I would have done that."

81. RN McLaren then completed a Health Problem Notification Form ("HPNF"). Under the heading "Signs/symptoms to look for in the inmate", she noted "Mental health history; observe for inappropriate laughing, isolation, mood, swings, agitation or aggression". These were matters RN McLaren considered indicative of a schizophrenic episode. If CSNSW Officers noticed any of these signs they were to contact the clinic or mental health immediately.

82. It was further noted that MH denied any suicidal ideation or intent and that he "must be placed 2 out cell placement until reviewed by Mental Health." This meant that MH was to be housed with another inmate. It was a matter for CSNSW to determine which inmate MH was to be housed with.

83. RN McLaren explained that the rationale behind the "two out" policy was so that the cellmate could use the cell intercom (known as the "knock up" button) to call for assistance if required.

84. RN McLaren did not have access to the CSNSW Offender Integrated Management System ("OIMS"). That system contains a series of alerts for inmates, including an alert for self harm or suicide. RN McLaren thought that it

would be useful for Justice Health nurses to have access to this system. However, I accept Counsel Assisting's submission that access to OIMS would not have made a difference to RN McLaren's assessment in this case as the focus of the assessment was on the identification of acute risk.

22 May 2017 – Intake Screener Questionnaire

85. On 22 May 2017, an Intake Screen Questionnaire was completed with MH at Goulburn CC. The following matters were noted:

    (a) States diagnosis of schizophrenia and is medicated.

    (b) States he has just spent over a month in Chisholm Ross Centre.

    (c) States nil health issues, nil self harm or suicide issues.

    (d) States under influence of ice and heroin at time of offence.

    (e) Has support of his mother.

    (f) Referral to psychology, AOD support and education.

Issue (b) The adequacy of the intake process at Goulburn Correctional Centre

86. In relation to the intake and assessment process, Counsel Assisting submits that it appears to have been done adequately and notes that it is limited to identifying acute risk and that that was not apparent. No expert was critical of the intake and assessment process and I accept it was performed adequately.

23 May 2017 – Medication continued by Dr O'Dea

87. On 23 May 2017, Dr O'Dea, at the request of Justice Health nursing staff, ordered the continuation of MH's medication in accordance with his medication regime at the Chisholm Ross Centre, being 400mg of Clopixol weekly. Dr O'Dea did not see MH on that day and said it was common to receive a request to continue medication in that manner.

23 May 2017 – MH seen by Bronwyn Ford, CSNSW Psychologist

88. On 23 May 2017, MH was seen by psychologist Bronwyn Ford. Ms Ford is employed by CSNSW. Being a CSNSW employee she does not have access to Justice Health records.

89. At the time of seeing MH, Ms Ford was working four days a week and was one of two psychologists employed at Goulburn CC. There are now three psychologists, and Ms Ford told the Court this had not eased the workload for her team.

90. In relation to her role, Ms Ford gave evidence that:

> "We don't generally get an opportunity to provide treatment because of staffing issues and our focus on risk assessment and – yeah, the risk and assessment and the needs and responsivity to rehabilitation. We generally only have the resources and capacity to provide brief interventions."

91. Ms Ford's immediate concern is to keep a prisoner safe whilst in custody.

92. Ms Ford had previously seen MH when he was an inmate at Goulburn CC earlier in 2017. When she saw MH on 23 May 2017, Ms Ford found him difficult to engage. MH sat with his eyes closed and was mumbling to himself. He gave contradictory answers and was difficult to talk to. He denied any history or current thoughts of self harm.

93. Ms Ford recorded on OIMS:

> "Inmate reported very poor sleep and stated he is really tired. Inmate stated he is stable on antipsychotic medication. Inmate stated that he wants to deal with all the issues in his past. Advised him that as psychology is short-staffed we are unable to provide that type of service at this centre or provide a safe environment to deal with those sort of issues."

94. Ms Ford clarified that by "those sort of issues" she meant any childhood trauma or issues he may have been talking about.

95. Ms Ford noted on OIMS that there was no further contact arranged at this time. Ms Ford explained that that was because MH said that he didn't want

engagement with psychology other than to talk about the issues they were not equipped to address.

96. At the time of Ms Ford's interaction with MH, the senior psychologist was on extended leave. As a result, Ms Ford and one other registered psychologist provided the psychology services for the entire gaol. At that time the prison population was around 600.

97. Upon reflection, Ms Ford said that if a prisoner presented similarly in the future, she would try to engage them a little bit more and try to get more information about how they were coping.

25 May 2017 – MH seen by Michael Harris, Justice Health Nurse

98. On 25 May 2017, MH was seen in the Justice Health Clinic by RN Michael Harris RN Harris was a very experienced mental health nurse, who had been employed at Goulburn CC since 1991.

99. Prior to seeing MH on 25 May 2017, RN Harris had treated or reviewed MH on a number of occasions when MH had previously been detained at Goulburn CC, including as a member of the Risk Intervention Team ("RIT") that reviewed MH in June 2016. RN Harris was not one of the nurses involved in treating MH when he self harmed in March 2017.

100. MH was paged to attend the clinic for administration of his depot medication and review. He arrived around 11:30am. During that appointment, MH voiced to RN Harris an objection to the frequency with which his medication was being administered. MH reported that it was making him too drowsy and that was "the last thing he wanted or needed whilst being in custody". MH presented to RN Harris as quite reasonable and rational and did not become agitated or aggressive. As compared with previous interactions, RN Harris observed nothing of concern in MH's presentation.

101. RN Harris checked MH's discharge summary from the Chisholm Ross Centre to confirm the dosage of 400mg weekly. In his experience this seemed a fairly high dose at this frequency. RN Harris then discussed this matter with Dr Sarah-Jane Spencer, the psychiatrist on duty in the clinic. He relayed to her MH's concerns.

Dr Spencer did not see MH but agreed to reduce his medication. Dr Spencer's decision is discussed further below.

102. RN Harris recorded in the notes:

> "Seen in clinic from waitlist and for depot intramuscular injection of Clopixol. Patient known to me from previous sentences. Most recent discharge summary from Chisholm Ross indicates 400 milligrams Clopixol weekly which patient objects to. He was open to discussion on this point. See Dr Spencer's notation above. Placed on psychiatrist's waitlist for review of dose and frequency. Patient states he's copying okay and no reported problems with others, cellmate okay, nil obvious acute or active psychoses evidence. Minimal insight into his substance use and exacerbation of his mental illness. Agreed to accept 400 milligrams of Clopixol every fortnight until psychiatrist's review."

103. RN Harris was responsible for allocating the level of priority for MH's review by a psychiatrist. RN Harris prioritised MH '4' or 'routine' on the Justice Health Patient Administration System ("PAS"). This meant that MH had to be seen within 12 months. It is these PAS waitlists that are reviewed by the mental health nurses to determine the list of patients to be seen in the psychiatrist's clinics when held.

104. When waitlisting MH, RN Harris recorded in the comments section on PAS: "History of schizophrenia, requires review of Clopixol dose and frequency. Recent return to custody, next court date late June 2017."

105. Dr Nielssen, a forensic psychiatrist providing expert evidence to the Court, gave evidence that a 12 month wait for an assessment was "absurd" and that a patient in MH's position really should be seen at the first clinic if their medication has been changed.

106. RH Harris' evidence was that just because a patient was prioritised as 'routine' this did not mean they would have to wait for 12 months to be followed up. The comments entered onto the PAS system would be reviewed by mental health nurses, who could then adjust the waitlist as required.

107. RN Harris said that it was the "usual objective" for someone in MH's position with chronic schizophrenia and acute episodes at different frequencies to see a psychiatrist within a relatively short period after having entered into custody. He explained that this is why those matters were noted in the comments.

108. RN Harris said that he now thought that MH should have been allocated a '2' or a '3' and could not recall why he listed him as '4'. RH Harris said it might have been an error of judgement or an error with the actual process of the computer on the day.

109. Ms Doust submits that the categorisation of MH as a priority 4 was either an error in entering the priority number in PAS or an error due to not having enough time, rather than an error of judgment on the part of RN Harris. However, in circumstances where RN Harris' evidence is that he cannot recall why he prioritised MH as a 4, that submission cannot be accepted.

110. In my view, RN Harris' concession that MH should have been allocated a higher priority on the waitlist, was appropriate. I acknowledge, however, that the numerical priority category assigned to a patient was not the only mechanism available to Justice Health nurses to organise the psychiatrists' waitlist. Those mechanisms included consideration of the comments entered against the entries on the waitlist and the time that had elapsed since the patient was last seen. I accept also that the presentation of patients for their depot injection provided a further opportunity for patients to be, as least superficially, reviewed and monitored by the mental health team.

25 May 2017 – Medication reduced by Dr Spencer

111. Dr Sarah-Jane Spencer is a forensic psychiatrist. She is presently employed by Justice Health as the Clinical Director, Custodial Mental Health. In May 2017, Dr Spencer was the Deputy Director, Custodial Mental Health.

112. On 25 May 2017, Dr Spencer was conducting a clinic at Goulburn CC. At around 2:00pm, near the end of her clinic, she was approached by RN Harris who informed her that MH was did not want to take his medication. Dr Spencer said that this occurred during lock in and there was no opportunity to see MH.

113. RN Harris told Dr Spencer that he felt MH was at baseline as compared to how he had presented on previous occasions and that MH reported he was experiencing side effects. RN had MH's medication chart which showed his current medication to be 400mg IMI Clopixol weekly. Dr Spencer gave evidence

that this was not a recommended dose in MIMS and that normally the maximum is 400mg every fortnight.

114. Dr Spencer recorded in the notes:

> "Asked to review medication because patient refusing 400 mg Clopixol IMI weekly, it is a large dose. Patient agreeing to take 400 mg IMI every two weeks. Previously on 200 mg every two weeks, from ROI [release of information] in 2016
>
> - No time to review now.
>
> - Plan: 400mg clopixol IMI every 2 weeks, due 31/5/17. For psychiatric review when possible."

115. As indicated by the above note, Dr Spencer reviewed MH's previous medical notes and noted that in the past he had received a dose of 200mg IMI Clopixol every two weeks. Dr Spencer reduced MH's dose from 400mg IMI Clopixol weekly, to 400mg every two weeks.

116. Counsel Assisting submits that I would not be critical of the decision to alter the interval for medication as requested by MH. I accept that submission. Neither Dr Sullivan nor Dr Nielssen were critical of the decision of Dr Spencer to reduce the frequency of MH's medication, although both noted that it is preferable to see and assess a patient before adjusting their medication.

117. During his final period of detention at Goulburn CC, MH, despite the severe and chronic nature of his illness, was not reviewed by a psychiatrist. Counsel Assisting asked Dr Spencer if she agreed that the fact that MH did not see a psychiatrist indicated he did not receive adequate care. Dr Spencer said that it would have been good if he had seen someone. Dr Spencer explained why she had not recorded, in her note, a particular priority for MH's review in the following way:

> "So there are lots of patients who come into custody not on any medication and not agreeing to take any medication and they do tend to be the priority from a psychiatrist's point of view, because we're the only ones who can prescribe. He had also had a period of inpatient treatment, whereas lots of patients have come in off the street and haven't had that opportunity, and I think that the team in Chisholm Ross had determined he was well enough to be remanded into custody, and Dr Sharma is someone who works in custody and so has knowledge of the resource constraints,

what is available in custody and the limitations, and the team made that decision. So based on that and the large proportion of patients who are in Goulburn unwell and not taking treatment at that time, he wasn't a priority to be seen for me."

Issue (c) Was the monitoring and clinical management of MH appropriate and otherwise in accordance with best practice

118. This issue is one of significance. As the inquest progressed, its focus began to shift from consideration of whether the monitoring and clinical management of MH was appropriate, to consideration of whether prisoners like MH, who suffer from a severe chronic mental illness, are even capable of being appropriately cared for in NSW prisons.

119. In considering the appropriateness of MH's clinical management, and the reasons for any identified failings, I was greatly assisted by the evidence of the experienced health professionals, some in their capacity as experts, who gave evidence at the inquest. I give significant weight to their evidence.

Forensic Psychiatrists – Dr Olav Nielssen and Dr Danny Sullivan

120. The Court received expert evidence from Dr Olav Nielssen and Dr Danny Sullivan.

121. As previously stated, Dr Nielssen is a consultant forensic psychiatrist who holds appointments at St Vincent's Hospital in Sydney. Dr Nielssen has previously held appointments at the MHRT and Justice Health.

122. Dr Sullivan is a consultant forensic psychiatrist who is Executive Director of Clinical Services at Forensicare, the state-wide public forensic mental health service in Victoria. Dr Sullivan has been a consultant at inpatient units and has worked at most of the prisons in Victoria in outpatient clinics.

123. Both experts agreed with Dr O'Dea's diagnosis of severe chronic schizophrenia with substance use disorder resistant to treatment, with Dr Sullivan observing that "every word in that diagnosis is relevant." Dr Nielssen and Dr Sullivan both agreed there was no basis to criticise any individuals involved in MH's care and that there were no acute signs of psychosis during his last period in custody that had been missed.

124. In his expert report, Dr Nielssen stated, in answer to the question, did MH receive adequate and appropriate care and treatment during his incarceration at Goulburn CC from 21 May 2017 – 23 June 2017:

> "The answer is obviously no, not because the staff who attended to him provided inadequate care, more because prison is such an inefficient place to treat people with severe forms of mental illness. We know that between 5% and 7% of NSW prisoners have schizophrenia, a condition that affects about 0.5% of the population, which means there are as many as 800 people with schizophrenia in NSW prisons at any one time. There are a total of around 1600 psychiatric beds in New South Wales, so that in effect prisons are our new asylums."

125. Dr Sullivan agreed with Dr Nielssen. Dr Sullivan told the Court:

> "I certainly have a strong personal belief that people with a health disorder should be treated in a health facility and people with a mental health disorder should be treated in a mental health facility, and that although there are numbers of people who remain in the prison system with a psychotic illness, that they can't get the most effective holistic multidisciplinary care that they would get in a hospital setting. Now you need to select which of the patients with a chronic mental illness in a prison system need to prioritised for that treatment, so in an ideal world, he would have been transferred, but of course, in the real world he would require active symptoms, non-adherence to medication or a significant risk to others to meet the threshold for transfer."

Psychologist - Patrick Sheehan

126. Patrick Sheehan is a highly experienced psychologist who has relevant experience in treating and assessing prisoners in the custodial environment. He gave expert evidence at the inquest.

127. Mr Sheehan opined that the level of support and supervision MH received in custody "fell well short of that offered in the Chisholm Ross Centre" and that this was "not a criticism but an inevitable difference between a correctional setting and a hospital setting". Mr Sheehan considered that MH's risk markers for self harm were chronic rather than acute. MH's "guarded presentation gave correctional staff little reason to suspect that he was floridly psychotic or at immediate risk of serious self harm".

128. Mr Sheehan agreed with the opinion of the expert psychiatrists that the custodial environment is not an appropriate place to treat prisoners with an illness like MH and that, therefore, MH could not receive adequate care at Goulburn CC.

Forensic psychiatrists at Goulburn CC – Dr O'Dea and Dr Spencer

129. Dr O'Dea gave the following answer to a question from Counsel Assisting about the role of a psychiatrist providing treatment to prisoners:

> "The usual situation in the prison system, because of the extent of psychiatric morbidity, particularly upon the severe end of the psychiatric spectrum, with psychosis, the usual thing is that we would do assessments of patients and instigate treatment, but of course, the treatment we would instigate, because of the practicalities of the situation, would usually be the medication. The idea of doing ongoing follow up with psychotherapy – which is something, of course that psychiatrists do all the time, but in prisons there's just not the opportunity from the workload, to do those kind of interventions. So essentially we would be assessing people and commencing the medication, which I might hasten to add is the single most effective intervention for these people in the context of also abstinence from substance use and being in a supportive environment which of course they're not necessarily in when they're in prison.

130. Dr O'Dea told the Court:

> "Prison is not a place to be treating people with severe chronic schizophrenia. They need to be treated in a hospital setting and prison is actually very adverse for their condition. You know, the problem is we don't – we aren't provided with the resources to do that and there's been frequent directives to governments – not just in New South Wales, across Australia and across the world – but governments haven't been able or prepared to do that. But you're quite right, it's very inappropriate to be treating people with severe mental illness in prisons. …
>
> [P]risons are the new asylums, and the level of psychiatric morbidity within prisons is enormous, and you know, unfortunately in closing psychiatric beds, severe mental illness hasn't gone away, it's just been relocated. And I think we've seen in this case somebody being transferred from a hospital to a prison, albeit because, as I understand it from reading the material, … they've been alleged to have committed an offence in hospital – but of course that, from my point of view would point very significantly to the fact that they have some major mental illness going on at the time

and they could be managed with the hospital in a secure setting, as we do in other hospitals, but of course, the resources are just not there."

131. Dr Spencer gave evidence that in the prison environment the priority is given to people in the acute phase of their illness or at immediate risk of suicide or self-harm.

132. Accordingly, in circumstances where MH was not manifesting positive signs of his illness to CSNSW and Justice Health staff he was not accorded priority despite the severe and chronic nature of his illness.

133. Dr Spencer agreed that prison is not a therapeutic environment to treat somebody with a mental illness and that there is a significant shortage of beds to appropriately care for those patients suffering from a chronic mental illness.

Resolution

134. Counsel Assisting submitted that while the monitoring of MH would ideally have been more frequent, the failure to arrange for more frequent review by a mental health team was not the fault of any individual, but a reflection of how inadequate and inappropriate NSW prisons are for dealing with prisoners with chronic severe schizophrenia like MH.

135. I accept that submission. Prisoners who suffer from a chronic mental illness, like schizophrenia, in a severe form, require, at a minimum, closer monitoring and assessment than is capable of being provided under the present model of care.

136. The evidence in this inquest amply demonstrates that the needs of prisoners in NSW with a severe chronic mental illness such as schizophrenia cannot be adequately met. The existing model of care provision is incapable of meeting the complex needs of such prisoners. This was the view of each of the four experienced forensic psychiatrists, and one experienced psychologist, who gave evidence.

137. Dr Spencer gave evidence that Justice Health have developed a proposal for an alternative, more therapeutic model of care ("the renewed model"). [redacted]

[redacted]

138. [redacted]

139. In addition to the oral evidence given by Dr Spencer, the Court received a copy of a document outlining the renewed model. As that document is the subject of a non-publication order I will not detail its contents further. Suffice to say, having reviewed the document, and heard the evidence of the witnesses in this inquest, the case for its implementation is compelling.

29 May 2017 – Self-tattooing

140. On 29 May 2017, MH was brought to the Health Centre for review of laceration to his right thumb due to self-tattooing. The wound was cleansed, sterile strips and a simple dressing applied. His wound was reviewed on 31 May 2017 and was clean and dry requiring no further dressings.

Contact with Services and Programs Officer, Frances Crown

141. RH told the Court how challenging it was to support MH during this period of incarceration. RH said that she asked MH what he had done on the day of the incident and that upon hearing MH's answer, she formed the view that he had sexually assaulted someone which, understandably, she found particularly distressing.

142. RH said that this affected the way she was able to communicate with, and relate to, MH in the weeks that followed. MH and RH did continue to communicate over the phone, and, at MH's request, RH put money in his account on the condition it was not for drugs.

143. On 13 June 2017, RH contacted an Offender Services and Programs Officer, Frances Crown, and informed her that she wanted to cease contact with MH. Ms Crown recorded the following note of her conversation with RH in the Offender Integrated Management System ("OIMS"):

> "Phone call received from mother of offender RH who wants no more contact with MH due to phone call over weekend "being the last straw" and which was manipulative. She would not disclose further details.
>
> She will be sending in birth certificate and other ID documents for his valuables bag at the gaol. She will be changing her address and phone number. When this is done she will pass this onto the gaol but this information is not to be disclosed to the offender."

144. RH described her emotional state at this time as "hurt, confused, angry, under stress."

145. RH sent a letter to Ms Crown dated 13 June 2017, confirming her conversation, and enclosing some of MH's property. She sent the letter to Ms Crown so that someone would convey the information to him.

146. RH gave evidence that she had a further conversation with Ms Crown within about a week of the first conversation and that during that conversation Ms Crown said to RH words to the effect "You can block MH's calls". RH said that by this time she was growing reluctant to cease contact with MH because she still enjoyed spending moments with him over the phone.

147. RH said that she then asked Ms Crown not to provide MH with the letter until after MH's court hearing on 21 June 2017, and that she would see what happened after Court. RH said that she asked Ms Crown to call her after the Court appearance, so that they could discuss the letter.

148. Ms Crown gave evidence that she could recall the conversation with RH on 13 June 2017, but no subsequent call. There is no OIMS note record of such a call. Ms Crown did not think that a second conversation occurred.

149. The conflict in the evidence between RH and Ms Crown will be discussed further below.

150. Despite RH's misgivings, there were further calls between RH and MH on 14, 15, 16, and 19 June 2017.

21 June 2017 – Court attendance and notification about R's calls

151. On 21 June 2017, James Apps, a CSNSW Officer, escorted MH to the AVL booth for his court appearance. Mr Apps sat in a separate booth and did not hear what occurred during the appearance. Mr Apps noticed nothing unusual in MH's appearance or demeanour, noting that he only interacted with him for a short time. Mr Apps recorded in OIMS:

> "Inmate attended video link today for Goulburn Local Court. Nil issues. Inmate was assisted by intellectual disability services."

152. RH sat beside MH's solicitor during his court appearance so that MH could see her. They were in Court for about five minutes and MH gave her a shy smile which RH said was typical of him.

153. That same day, after the Court appearance MH was seen by Ms Crown who informed him that RH wanted to cease contact. The conversation occurred in Ms Crown's office and lasted for around 15 minutes. Ms Crown recorded the following note of the conversation in OIMS:

> "Offender seen to pass on news that his mother RH does not want to have further interaction with him due to a phone call where she felt manipulated, I suggested it might have had something to do with asking for drugs or money. He did not disagree or agree. The information explained further to offender that property had been sent to the gaol and placed in his property. Offender appeared to understand but did not react. Said I would see him again on Friday as officers called him away. Further information needs to be given."

154. Ms Crown said that MH appeared calm when given the information and that she was aware he might be distressed to hear his mother wanted to cease contact. She had tried to deliver the information gently.

155. Ms Crown explained that the "further information" referred to in the OIMS note concerned aspects of the letter she had not had the opportunity to inform him of including information regarding Dooralong and money that he believed he had been owed.

Issue (d) - The adequacy and appropriateness of communications between MH and CSNSW staff

156. As set out above, Ms Crown and RH have differing recollections of the number of conversations they had during MH's last admission to Goulburn Correctional Centre and of the content of those conversations.

157. Counsel Assisting submits that it is unfortunate that there was a communication breakdown between RH and Ms Crown and that it is difficult to resolve the factual dispute that arises, but also not possible to determine that it had any impact on MH's death.

158. Ms Lewer submits that, with respect to the issue of whether a second conversation occurred, I would prefer the evidence of RH, first, on the basis that RH is recalling evidence about a highly significant matter which she is likely to remember and, secondly, that the timing of the meeting between Ms Crown and MH corroborates RH's version.

159. Both Mr Broad and Mr Russell submit that it is not necessary for me to determine whether the second conversation occurred.

160. I accept that it is not necessary for me to determine whether the second conversation occurred as I do not consider there is sufficient evidence for me to find Ms Crown's conversation with MH had any impact on MH's death.

161. Ms Lewer submits that, with respect to Ms Crown's meeting with MH, Ms Crown failed to properly discharge her obligations to MH to complete any real risk assessment about a risk of self harm after she delivered the news to MH about RH's proposed cessation of contact with him. Ms Lewer submits that failure may

have arisen because the meeting was cut short, however, given that fact and the contents of the news Ms Crown had given, she ought to have taken steps to ensure some other person conducted a risk assessment or that MH was monitored for signs of self harm upon his return to the wing. Ms Lewer submits these failures contributed to MH's death.

162. Mr Broad submits that: Ms Crown met with MH in the privacy of her office so that she could provide him support; that she tried to deliver the message gently; and, that she monitored MH for any adverse reaction. Ms Crown's evidence was MH had not appeared distressed and, accordingly, she did not alert others to the possibility that MH might self harm. Mr Broad further submits that it is highly speculative to suggest that had MH been closely monitored upon his return to the wing his risk of suicide would have been detected.

163. Mr Russell submits that MH was not presenting or behaving in a manner that would support a contention that he was at risk of self harm and therefore Ms Crown was not required to raise a mandatory notification or refer him for a risk assessment.

164. As previously indicated, I do not consider there is sufficient evidence for a finding that Ms Crown's interaction with MH impacted upon his death. I accept, as Counsel Assisting submits, that an inference can be drawn that receiving news that his mother wished to cease contact with him would have been upsetting. However, Ms Crown, who accepted that it forms part of her role to look out for signs and symptoms of risk, gave evidence that MH appeared calm when he received the news.

165. In circumstances where Ms Crown monitored MH for an adverse reaction to the news she delivered and he displayed no such reaction, I do not accept the submission that Mr Crown ought to have taken steps to ensure some other person conducted a risk assessment or otherwise monitored MH for signs of self harm.

166. In making this finding I give weight to the evidence of Mr Sheehan who told the Court that it was not realistic to expect additional supports to be put in place around the delivery of information such as that delivered to MH. Mr Sheehan

pointed out the delivery of information that might be upsetting to inmates is not uncommon as it is often the case that, for prisoners, their relationships and lives are “in chaos”.

22 June 2017 – Entire Centre Search

167. On 22 June 2017, Goulburn CC was locked down for the duration of the day for the purposes of conducting an “Entire Centre Search”. The razor blades MH would later use to harm himself appear not to have been located.

22 June 2017 – Last known contact between MH and a Correctional Officer

168. On 22 June 2017, at around 2:00pm, First Class Correctional Officer Michelle Lynch opened Cell-66, where MH was housed with his cellmate [redacted], to deliver their evening meals. Office Lynch sighted MH standing towards the rear of the cell.

169. At around 5:05am the following morning, Senior Correctional Officer Darren Wake was called by Correctional Officer Conway Bogg in the Control Room to say that he had just received a “knock up” call from MH’s cellmate that MH was hanging himself. A number of CSNSW Officers then attended the cell. They discovered MH hanging. One end of a bedsheet had been tied to a bar of the cell window and the other was tied to MH’s neck.

170. Correctional Officers entered the cell and removed [redacted] securing him to railing outside the cell. Officers lifted MH to cut the bedsheet from his neck using the 911 tool. MH was then lowered to the ground where CPR was commenced. Efforts to resuscitate MH continued until the arrival of NSW Ambulance Officers at about 5:20am. The efforts to resuscitate MH were recorded by CSNSW Officers.

171. Ambulance Officers conducted a medical assessment and informed CSNSW staff there was nothing further that could be done as there were no signs of life. At 6:05am, Justice Health Registered Nurse Susan Miller and Roy McNair, Manager of Security, attended Cell 66. Nurse Miller assessed MH and completed a ‘Life Extinct’ form.

172. At around 8:00am, Detectives from Goulburn Police Station and Crime Scene Officers attended the scene. Detectives from the Corrective Services Investigation Unit and Investigators from the Investigation Branch CSNSW later attended.

173. The scene was processed by Senior Constable Brenton Day. It was identified that MH had injured himself by making cuts to his neck area and forearm with a broken gaol issue razor blade prior to hanging himself. Blood was located on the wall (below the rear window of the cell) and floor below the window. The pillow and sheeting on the top bunk, where MH had slept, also had an amount of blood on it. A razor blade was located on the top bunk. A number of letters and poems were collected.

174. [redacted] was interviewed by Police on 23 June 2017. The Officer in Charge in this inquest, Detective Joseph Coorey, was one of the officers who interviewed [redacted] Detective Coorey gave evidence that he kept an open mind as to the circumstances of MH's death. Detective Coorey told the Court that there was no inconsistency between the forensic evidence and [redacted] version of events. There was no evidentiary basis to consider that [redacted] had any involvement in MH's death.

175. [redacted] had been MH's cellmate for about one month. He too suffered from schizophrenia and was treated with fortnightly injections.

176. [redacted] told Police that on 21 June 2017, he and MH had exercised together in the yard and lay in the sun, laughing and joking around. During the lockdown on 22 June 2017, [redacted] noticed MH was wearing rosary beads and reading aloud from his prayer book. He said that MH had not done this before and that he was being secretive. Later that evening [redacted] and MH listed to the radio through the television.

177. [redacted] told Police that around 4:00am on 23 June 2017, he woke up to get a drink of water and noticed MH underneath the window. [redacted] grabbed the sheet and felt how tight it was. He buzzed the cell intercom to alert CSNSW Officers. [redacted] told Police he had no idea that MH was planning to take his own life.

Cause of death

178. An autopsy was performed by Dr Rebecca Irvine on 28 July 2017. Dr Irvine determined the cause of death to be hanging. She noted a superficial incised wound on the anterior neck and two vertical incised wounds on the right forearm. The forearm wounds sat atop a rectangular area of concentrated linear scarring.

179. Toxicological examination showed a nontoxic range of blood concentration of mirtazapine (an anti-depressant) which had not been prescribed to MH. Also detected was a low toxic range of blood concentration of zuclopenthixol (Clopixol), the antipsychotic medication MH was prescribed. No other drugs or alcohol were detected.

180. There was evidence that MH had used buprenorphine whilst in custody, buying it from fellow inmates. However, the toxicology results demonstrate that any use by MH of buprenorphine was not directly related to the cause of death.

Issue (a) Was the death self-inflicted and/or precipitated by a mental illness episode?

181. Counsel Assisting submits there is ample evidence to be satisfied, on the balance of probabilities, that MH's death was intentionally self-inflicted. I accept that submission. The forensic evidence is consistent with the account of MH's death given to Police by his cellmate and there are no suspicious circumstances.

182. I am satisfied that MH intended to take his own life, by hanging, having shortly before cut himself with a razor blade later located in his cell.

183. With respect to the issue of whether MH's death was precipitated by a mental illness episode, Counsel Assisting submits that it is likely the MH's death was precipitated by the reappearance of some intrusive psychotic thoughts, given the evidence of his cellmate.

184. I accept that submission. The evidence in relation to MH's illness was that his symptoms fluctuated over time and, as Counsel Assisting submits, the evidence of MH's cellmate supports the view that MH was experiencing intrusive psychotic thoughts.

Issue (e) The effect, if any, on MH of the level of zuclopenthixol detected in MH's blood post mortem

185. Counsel Assisting submits that the level of zuclopenthixol detected post mortem is not likely to have made any difference to the behaviour of MH or the tragic outcome.

186. Mr Jackson submits that 400mg weekly was an appropriate dose to prescribe within the context of MH's acute presentation in the context of a severe, treatment resistant, chronic schizophrenia. Further, no side effects were recorded during MH's stay at the Chisholm Ross Centre, and no side effects are particularised in the Justice Health records.

187. Both Dr Nielssen and Dr Sullivan addressed this issue in their expert reports.

188. Dr Nielssen stated that zuclopenthixol is very tissue bound and that blood levels are not closely correlated with either clinical effects or side effects. In relation to any effect on suicidal ideation, Dr Nielssen observed:

> "The main problem would appear to be the lack of an effect on acute symptoms, based on the various observations and the content of MH's writings. …
>
> There were no reports of akathisia, or motor restlessness, which is a particularly distressing neurological side effects of potent antipsychotic medication especially in confined quarters, and I did not find any entries in the CRC or prison records commenting on the neurological side effects of a potent form of antipsychotic medication. However, the untidy form of MH's handwriting suggests the presence of neurological side effects from a high dose of zuclopenthixol."

189. Dr Sullivan, in his report stated:

> "Post mortem toxicology indicated toxic concentrations of antipsychotic medication. However, there was no evidence of movement side-effects, sedation or other clinical suggestions of toxic levels of medication while MH was alive. In the absence of other evidence, this may reflect post mortem redistribution of medication in body tissues rather than preceding toxic levels."

190. In her oral evidence, Dr Spencer said that when RN Harris asked her to review MH's medication, he reported to her that MH had asked for his medication to be

reduced because he was experiencing side effects. Dr Spencer could not recall what those side effects were and did not document them in MH's medical record.

191. Dr Spencer reduced MH's medication on 25 May 2017. Other than Dr Nielssen's observations of MH's handwriting, there is no documentary or oral evidence to suggest MH was suffering from any further ill effects relating to his medication.

192. In my view, on balance, the evidence establishes that that the toxic level of zuclopenthixol detected in MH's blood post mortem had no impact upon the circumstances of MH's death.

Issues relating to CSNSW

Issue (f) - Whether MH was appropriately housed at Goulburn Correctional Centre

193. As stated above, MH was housed two-out in a cell with [redacted].

194. The purpose of housing inmates in MH's circumstances with a cellmate was explained by the Governor of Goulburn CC, Mr Wayne Taylor as follows:

> "The two out system, colloquially it's defined as the buddy system. So it is normally put together as a risk management strategy to ensure that by placing people two out there's always someone else that could, you know, call for help or raise the alarm, or even just for comfort to talk and just for basic human comfort. They place it on the buddy system so you haven't got someone determined at risk or possibly at risk by themselves."

195. Whilst the "buddy system" has limitations it was, in my view, appropriate, in the circumstances, to house MH with a cellmate. The "buddy system" provides an opportunity for an inmate to raise the alarm should he or she have concerns about their cellmate which is what MH's cellmate did after becoming aware that MH had self-harmed.

196. With respect to the choice of cellmate for MH, [redacted] was himself diagnosed with schizophrenia and was receiving sedating medication. He does not appear to have woken up when MH was preparing to hang himself. Rather he awoke around 4am to get a glass of water and discovered MH hanging beneath the cell window.

197. Mr Taylor gave evidence that CSNSW are not normally informed of the medication an inmate is receiving with the effect that this was not ordinarily a matter that could be taken into account in determining which inmates were housed together in the same cell.

198. Dr Nielssen, who had treated MH's cellmate some years before, described him as a "calm older guy" and observed that "a very high proportion of prisoners are on psychotropic medication that's sedating, so you would have trouble finding one almost, you know, in that sort of clinical area."

199. In light of this evidence, I accept Counsel Assisting's submission that there is no basis for criticism with respect to the housing of MH.

Issue (g) Whether all appropriate measures were taken to remove self-harm implements and hanging points from the cell occupied by MH

Access to razors

200. As previously stated, MH was discovered in his cell with cuts to his neck and forearms. A broken gaol issued razor blade was found in his cell.

201. Mr Taylor gave evidence that certain inmates can have their access to razors restricted and are supervised when shaving. Those restrictions are, however, limited to inmates on a RIT or where there is an acute risk of self harm. In circumstances like MH's, however, where a previous suicide attempt and an incident of self harm in the custodial setting had occurred some time ago, those restrictions would not apply.

202. Mr Taylor gave the following evidence about the reasons for this approach:

> "Because self-dignity, self-advocation, is what we're aiming for in this business and even when someone's had an episode and they're moving forward and they've presented and they've met all the pre-requisites, and they're moving forward, then they should be given the opportunity to move forward. Yes, it's a difficult road to tread; yes, we need to take into consideration especially mental health, you wouldn't get someone actively psychotic to be starting making guarantees about their own safety, but the professionals would gauge that and

– but it's about moving forward with people and personal hygiene is one of the big things we're aiming for to get people back on track. So again, it's one of those issues – and I'll just make note that we do supply razors on their buy up, so they buy a different, better one on their buy up. Within the organisation we work on risk. Where the risk is high, then we act. Where the risk is low, then the person gets their benefits and civil liberties that you are entitled to whilst you're in prison."

203. This approach is a thoughtful and considered one, which appropriately balances the safety and security of inmates with the liberties and dignity to which they remain entitled.

204. I accept the submission made by Counsel Assisting that CSNSW Officers did not have any immediate concerns that MH might potentially self-harm and, on that basis, restricting his access to a razor would not have been warranted.

Hanging Points

205. Photographs taken of Cell 66 shortly after MH's death reveal that the bed sheet with which MH constructed the ligature was attached to a bar across the window at the rear of the cell. Mr Taylor accepted that this was a hanging point that would have been obvious to MH.

206. Fresh photographs of Cell 66 were received into evidence. Those photographs reveal that since MH's death [redacted]

207. Mr Taylor gave evidence that all cells in Goulburn Correctional Centre [redacted] has had the effect of preventing access to the bars thereby removing the hanging point.

Findings required by s. 81(1)

208. As a result of considering all the documentary and oral evidence given at the inquest, I confirm that the death occurred, and I make the following findings.

The identity of the deceased

The person who died was [redacted]

Date of death

23 June 2017

Place of death

Goulburn Correctional Centre

Cause of death

Hanging

Manner of death

Intentional self-inflicted death, and was likely precipitated by a mental illness episode.

Recommendations

First recommendation proposed by Counsel Assisting

209. Counsel Assisting has proposed the following recommendation directed to the CEO of Justice Health: That Justice Health implement the [redacted] ("renewed model") and that such model be separately funded and resourced independent of the need to reallocate resources from the existing model of care.

210. This recommendation is supported by Ms Lewer.

211. Mr Harris submits that this recommendation is neither necessary nor desirable because, first, the Ministry of Health is already considering the renewed model. Secondly, the nature and funding of Justice Health services is a matter for NSW Health and Justice Health would not support a recommendation being made to the Ministry of Health to fund the renewed model in circumstances where the Ministry is not a party of sufficient interest.

212. Mr Harris proposes a recommendation that those assisting the Court provide a copy of its findings to the Ministry of Health for consideration together with the Renewed Model.

213. The Commissioner of CSNSW generally supports the implementation of the Renewed Model in consultation of CSNSW.

214. Mr Broad draws attention to a recommendation in identical terms to that posed by Counsel Assisting that was considered by Deputy State Coroner Ryan in the *Inquest into the death F.* Her Honour delivered findings on 11 June 2021. Her Honour declined to make the recommendation in the terms suggested by Counsel Assisting as her Honour accepted the submission of Justice Health that it was unable to implement the model without the agreement and funding of the Ministry of Health which was not a party of sufficient interest.

215. I accept that for reasons of fairness, and because I have not had the benefit of their submissions, it would not be appropriate to make a recommendation directed to a party who did not have a sufficient interest in the proceedings.

216. However, as stated above I consider the case for the implementation of the renewed model to be compelling.

217. I accept that the course proposed by Mr Harris is appropriate. Accordingly, I will request that those assisting me provide a copy of these findings to the Ministry of Health for consideration together with the Renewed Model.

Second Recommendation proposed by Counsel Assisting

218. Counsel Assisting proposed a further recommendation: That consideration be given to developing health care plans for patients at Goulburn Correctional Centre who suffer from chronic and major mental health illness with such a health care plan being updated as necessary by the care coordinator/case manager and including, amongst other relevant matters:

- Diagnosis;
- Medication;
- Cell placement;
- Target frequency of review;
- Early warning signs of deterioration or relapse;

- Target interventions including metabolic monitoring, psychology, employment, other psychosocial supports;
- Risk management and recovery plan; and,
- The wishes of the patient and family.

219. This recommendation is supported by Ms Lewer.

220. Mr Harris submits that the inquest did not hear any evidence in relation to the consequences of implementing health care plans, including their utility, benefits or disadvantages, cost or resource consequences, or barriers to implementation within a custodial setting. Mr Harris submits that given the lack of exploration of the topic of health care plans it would not be necessary or desirable to make this recommendation.

221. I accept that the issue of health care plans was not explored in detail in the inquest. However, the recommendation is carefully framed so as to invite Justice Health to "give consideration to" the proposal. I note that Justice Health is currently considering ways in which its systems could be updated to provide a live case management plan for chronically ill patients and observe that I consider it to be a very worthwhile endeavour.

Recommendations proposed by RH

222. Ms Lewer has proposed 26 recommendations for my consideration. Seven of these recommendations are addressed to either NSW Health or NSW Police, at least in part. For the reasons stated above I do not consider it appropriate to make a recommendation to a party who has not been put on notice or been granted leave to appear as a sufficiently interested party in the Inquest. Accordingly, I decline to make proposed recommendations (c) (h), (i), (v), (w), (y) and (z).

223. Both Mr Broad and Mr Harris draw attention to the terms of s. 82 of the *Coroners Act 2009* which relevantly provides that a recommendation may be made "in relation to any matter connected with the death". I accept that where I am not satisfied that a recommendation is sufficiently related to MH's death, I am unable to make that recommendation.

Recommendations (a) and (b)

224. Ms Lewer proposes that:

> (a) Consideration be given to amending s. 86(2) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* to either:
>
> (i) mandate a time period in which an inmate must be seen by a second medical practitioner once the first medical practitioner has issued a certificate in relation to the transfer of an inmate to a mental health facility or
>
> (ii) require an inmate must be seen by a second medical practitioner once the first medical practitioner has issued a certificate in relation to the transfer of an inmate to a mental health facility as soon as practicable.
>
> And
>
> (b) Consideration be given to amending the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* so that obligations similar to those owed to principal care providers and designated carers under the Mental Health Act 2007 also apply in circumstances where a Schedule 1 under the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* has been completed or an order for transfer has been made by the Secretary pursuant to s. 86(1) of that Act, irrespective of whether the patient has actually been transferred to a mental health facility.

225. Mr Harris submits that recommendations (a) and (b) are not matters connected with the death, as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017. Further, in relation to recommendation (a) Mr Harris submits given Dr O'Dea completed the Schedule 12 months prior to MH's death, the desirability of a particular time period for review by a second practitioner does not arise on the facts of the case.

226. I accept these submissions and decline to make the recommendation proposed.

Recommendation (d)

227. Ms Lewer proposes that where Corrective Services does not have sufficient or appropriate inpatient facilities for an acutely mentally ill inmate within the forensic

environment, Justice Health is to implement s. 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* on every occasion it is so required and arrange for the immediate transfer of the inmate to the nearest available mental health facility.

228. Mr Harris submits that this recommendation is not a matter connected with the death as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017.

229. I accept this submission and decline to make the recommendation proposed.

Recommendation (e)

230. Ms Lewer proposes that consideration be given to conducting research into the feasibility and clinical benefits of treating all acutely mentally ill inmates in NSW in a secure facility rather than in the general prison population.

231. Mr Harris submits that this recommendation is not necessary or desirable on the basis that there has been significant research conducted internationally into these issues. The inquest heard no evidence on the desirability or resource implications of conducting further research.

232. I accept this submission and decline to make the recommendation proposed.

Recommendation (f)

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

234. Mr Harris submits that the work undertaken in preparing the Renewed Model has considered these issues.

235. I accept this submission and decline to make the recommendation proposed.

Recommendation (g)

236. Ms Lewer proposes that Justice Health undertake a review of the level of psychiatric care provided to inmates in correctional centres in NSW in light of the size, and projected size, of the prison population and to identify the resourcing and other actions that would be required to provide an appropriate level of care to a prison population of that size.

237. Mr Harris submits that the work undertaken in preparing the Renewed Model has considered these issues.

238. I accept this submission and decline to make the recommendation proposed.

Recommendation (j)

239. Ms Lewer proposes that Justice Health implement a policy requiring that once a certificate has been issued under s. 86(2) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020,* the inmate must be seen by an appropriate medical practitioner for the purposes of consideration of the second certificate within 72 hours.

240. Mr Harris submits that recommendation (j) is not a matter connected with the death, as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017. Given Dr O'Dea completed the Schedule 12 months prior to MH's death, the desirability of a particular time period for review by a second practitioner does not arise on the facts of the case. Mr Harris further submits that imposing a requirement that a second practitioner review a patient within 72 hours raises significant resource implications, in particular, in non-metropolitan areas, which were not explored during the inquest.

241. I accept these submissions and decline to make the recommendation proposed.

Recommendation (k)

242. Ms Lewer proposes that Justice Health implement a policy that once a certificate has been issued under s. 86(2) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020,* the inmate must be reviewed again by the psychiatrist within seven days.

243. Mr Harris submits that recommendation (j) is not a matter connected with the death, as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017. Given Dr O'Dea completed the Schedule 12 months prior to MH's death, the desirability of a particular time period for review by a second practitioner does not arise on the facts of the case.

244. I accept this submission and decline to make the recommendation proposed.

Recommendation (l)

245. Ms Lewer proposes that Justice Health implement a policy requiring an inmate who is prescribed antipsychotic medication for a major mental illness be admitted under the care of a primary clinician who is responsible for their care.

246. Mr Harris submits that within Long Bay Hospital, the Mental Health Screening Unit or Hamden POS, a patient is admitted under the care of a primary clinician. However, in other locations the model of care is not "psychiatrist-led", in circumstances where a psychiatrist is available only intermittently at most correctional centres.

247. I accept this submission and decline to make the recommendation proposed.

Recommendation (m)

248. Ms Lewer proposes that Justice Health implement a policy requiring any inmate who is prescribed antipsychotic medication for a major mental illness to be reviewed within seven days by the primary clinician who has prescribed their medication

249. Mr Harris submits that while it would be ideal for patients to be reviewed within 7 days, this is not always practicable, where psychiatrists are available only intermittently.

250. I accept this submission and decline to make the recommendation proposed.

Recommendation (n)

251. Ms Lewer proposes that Justice Health implement a policy requiring any inmate who is prescribed antipsychotic medication for a major mental illness to be

reviewed be a psychiatrist regularly and at least every 12 weeks unless and until a psychiatrist determines that such reviews can take place less frequently.

252. Mr Harris submits that this recommendation is not necessary or desirable where, in certain locations the model of care is not "psychiatrist-led", and a psychiatrist is available only intermittently at most correctional centres.

253. I accept this submission and decline to make the recommendation proposed.

Recommendation (o)

254. Ms Lewer proposes that Justice Health implement a policy requiring any inmate who has entered custody within 48 hours of being detained as a mentally ill person under the *Mental Health Act 2007* be reviewed by a psychiatrist within 7 days.

255. Mr Harris submits that that recommendation (o) is not a matter connected with the death, as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017. Mr Harris further submits that whilst this proposal is desirable it is not always practicable.

256. I accept this submission and decline to make the recommendation proposed.

Recommendation (p)

257. Ms Lewer submits that Corrective Services should implement a policy that at the time of reception into each correctional centre, inmates automatically be provided consent forms that permit Justice Health and Corrective Services to share medical information relating to the inmate. Such a form shall include an area whereby the inmate can specify whether it is all information or whether some specified information is or is not to be disclosed.

258. Mr Harris submits that recommendation (p) is not connected with the death as the evidence does not establish that this was an issue at the time of reception. Further the evidence did not explore the consequences of a proposal to share all or some of a patient's health information with CSNSW.

259. Mr Broad submits that the Commissioner of CSNSW does not support the implementation of this proposal as the lawful disclosure of health information in

accordance with any consent obtained from an inmate is squarely and appropriately within the remit of Justice Health and not CSNSW.

260. I accept these submissions and decline to make the recommendation proposed.

Recommendation (q)

261. Ms Lewer proposes that CSNSW implement a policy that at the time of reception into each correctional centre, inmates be automatically provided consent forms that permit Justice Health and/or Corrective Services to share information relating to the inmate with family member(s) or friend(s) of the inmate.

262. Mr Harris submits that recommendation (q) is not connected with the death as the evidence does not establish that this was an issue at the time of reception. Further the evidence did not explore the consequences of a proposal to share all or some of a patient's health information with CSNSW.

263. Mr Broad submits that the Commissioner of CSNSW does not support the implementation of this proposal as the lawful disclosure of health information in accordance with any consent obtained from an inmate is squarely and appropriately within the remit of Justice Health and not CSNSW.

264. I accept these submissions and decline to make the recommendation proposed.

Recommendation (r)

265. Ms Lewer proposes that CSNSW staff be required to undertake ongoing training and development in relation to identifying prisoners who are experiencing symptoms of a mental illness and risks of self-harm.

266. Mr Broad does not support the recommendation. He submits that MH did not manifest any signs or markers indicating he was at risk of suicide during the period of his incarceration leading up to his death. Further, the current CSNSW policy in relation to the management of inmates at risk of self harm or suicide provides an appropriate level of guidance to CSNSW staff about the identification and assessment of risk factors for suicide and self harm

267. I accept that submission and decline to make the recommendation proposed.

Recommendation (s)

268. Ms Lewer proposes that successful applicants to become a staff member of NSW Justice are required to complete basic training, and that this basic training should include a core compulsory subject in relation to identifying prisoners who are experiencing symptoms of mental illness and self harm.

269. Mr Broad does not support the recommendation. He submits that MH did not manifest any signs or markers indicating he was at risk of suicide during the period of his incarceration leading up to his death. Further, the current CSNSW policy in relation to the management of inmates at risk of self harm or suicide provides an appropriate level of guidance to CSNSW staff about the identification and assessment of risk factors for suicide and self harm.

270. I accept that submission and decline to make the recommendation proposed.

Recommendation (t)

271. Ms Lewer proposes CSNSW implement ongoing training and development for all staff employed in support and welfare roles in relation to delivery of all difficult news to inmates. Such training is to include methods and strategies that might be able to be utilised to deliver such news, observations about the inmate's response that should be considered, the supports that are available for the inmate when such news is delivered and arranging follow up for the inmate.

272. Mr Broad does not support the recommendation. Mr Broad submits that it is unclear what type of further training welfare officers could realistically undertake. Mr Broad submits that Mr Sheehan expressed the view that Ms Crown's approach was reasonable in the circumstances. Apart from the sensitive use of interpersonal skills to convey bad news Mr Sheehan was unable to identify any other skills or assurances that could be usefully deployed by a welfare officer.

273. I accept that submission and decline to make the recommendation proposed.

Recommendation (u)

274. Ms Lewer proposes that CSNSW conduct a review into the implementation of the "companion inmate" aspect of section 7.17 of its Operation Procedure Manual policy and provide reminders and training to its staff about the implementation of that policy.

275. Mr Broad does not support the recommendation. He submits that 7.17 of the Operation Procedure Manual has been replaced with COPP 5.2 which was last reviewed on 27 May 2020 and a cell placement guide added to the procedure.

276. I accept that submission and decline to make the recommendation proposed.

Recommendation (x)

277. Ms Lewer proposes that CSNSW and Justice Health work towards developing a consistent computer alert system in relation to self-harm, to ensure that both entities are aware of the risks that exist for a particular inmate.

278. Mr Harris submits that this recommendation is not necessary or desirable and that the HPNF already provides a system for alerting CSNSW staff to a patient's health problems.

279. Mr Broad submits that the need for development of a new computer alert system is not demonstrated and that CSNSW and Justice Health currently collaborate in identifying and managing an inmate's risk of self harm.

280. I accept these submissions and decline to make the recommendation proposed.

Conclusion

281. MH was, in RH's words, a poet, a beautiful heart and a very caring man. He was loved and cherished by his family and despite the challenges wrought by his illness he brought great joy to their lives. I express my sincere condolences to all those who knew and loved him.

282. RH, along with her sisters B and L, attended each day of the inquest. RH has been, and remains, a fierce advocate for her son. I thank her for her participation in this inquest.

283. I extend my thanks to the assisting team Dr Peggy Dwyer and Ms Amber Doyle and to the other legal representatives for their assistance.

284. I now close this inquest.

T M O'Sullivan
NSW State
Coroner

15 July 2021